Filed in District Court
State of Minnesota
9/23/2019

State of Minnesota
County of Aitkin

District Court
9th Judicial District

Prosecutor File No. 33.DA72.0201
Court File No. 01-CR-19-946

State of Minnesota,

Plaintiff,

vs.

THERESA LEE OLSON DOB: 12/13/1975

604 Summit Avenue
Hill City, MN 55748

Defendant.

COMPLAINT

Warrant

The Complainant submits this complaint to the Court and states that there is probable cause to believe Defendant committed the following offense(s):

COUNT I

Charge: Racketeering
Minnesota Statute: 609.903.1(1), with reference to: 609.904.1
Maximum Sentence: Imprisonment of not more than 20 years, or payment of a fine of not more than $1,000,000, or both.
Offense Level: Felony

Offense Date (on or about): 02/07/2017 to 02/05/2019

Control #(ICR#): 20190019

Charge Description: On or about February 7, 2017 through February 5, 2019, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975) was employed by or associated with an enterprise and intentionally conducted or participated in the affairs of the enterprise by participating in a pattern of criminal activity, to wit: Through her operation and management of Chappy's Golden Shores and acting in concert with other employees, OLSON fraudulently obtained, on behalf of Chappy's Golden Shores, $2,151,581.72 in funds from the Minnesota Department of Human Services and $18,802.72 from Medica for a total of $2,170,384.44, by participating in a pattern of criminal activity by committing three or more predicate acts, namely of theft by swindle and concealing criminal proceeds, by swindling the Department of Human Services through a series of intentional acts that concealed the nature of the services Chappy's Golden Shores provided and the eligibility of the services for reimbursement, and by concealing these criminal proceeds by conducting a transaction over $5,000 with knowledge that the transaction, withdrawing two cashier's checks, each in the amount of $869,351.00, from Chappy's business accounts the day after an onsite investigation from MDH, represented the proceeds of felony theft by swindle.

COUNT II

Charge: Theft by Swindle (over $35,000)
Minnesota Statute: 609.52.2(a)(4), with reference to: 609.52.3(1)
Maximum Sentence: Imprisonment of not more than 20 years, or payment of a fine of not more than

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$100,000, or both.
Offense Level: Felony

Offense Date (on or about): 08/07/2018 to 02/05/2019

Control #(ICR#): 20190019

Charge Description: On or about August 7, 2018 through February 5, 2019, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975) obtained property from another person by swindling, whether by artifice or trick, device, or any other means, and the value of the property obtained was over $35,000, to wit: OLSON, through Chappy's Golden Shores, obtained $1,294,889.86 from the Minnesota Department of Human Services and Medica, by billing for services to Medicaid recipients that were not eligible for reimbursement, of which $528,621.84 was obtained by billing for services provided after fraudulently receiving a comprehensive home care license by falsely asserting that Chappy's had a registered nurse on staff, and $526,173.75 was obtained by billing for services provided by individuals who had not passed a background study, and $231,043.31 was obtained by billing for services provided at an unlicensed facility, and $9,050.96 was obtained by billing for services that were not provided because a Chappy's resident was not at the facility.

COUNT III

Charge: Theft by Swindle (over $35,000)
Minnesota Statute: 609.52.2(a)(4), with reference to: 609.52.3(1)
Maximum Sentence: Imprisonment of not more than 20 years, or payment of a fine of not more than $100,000, or both.
Offense Level: Felony

Offense Date (on or about): 02/07/2018 to 08/06/2018

Control #(ICR#): 20190019

Charge Description: On or about February 7, 2018 through August 6, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975) obtained property from another person by swindling, whether by artifice or trick, device, or any other means, and the value of the property obtained was over $35,000, to wit: OLSON, through Chappy's Golden Shores, obtained $709,216.61 from the Minnesota Department of Human Services and Medica, by billing for services to Medicaid recipients that were not eligible for reimbursement, of which $463,586.95 was obtained by billing for services provided by individuals who had not passed a background study, and $236,036.93 was obtained by billing for services provided at an unlicensed facility, and $9,592.73 was obtained by billing for services that were not provided because a Chappy's resident was not at the facility.

COUNT IV

Charge: Theft by Swindle (over $35,000)
Minnesota Statute: 609.52.2(a)(4), with reference to: 609.52.3(1)
Maximum Sentence: Imprisonment of not more than 20 years, or payment of a fine of not more than $100,000, or both.
Offense Level: Felony

Offense Date (on or about): 08/07/2017 to 02/06/2018

Control #(ICR#): 20190019

Charge Description: On or about August 7, 2017 through February 6, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975) obtained property from another person by swindling, whether by artifice or trick, device, or any other means, and the value of the property obtained was over $35,000, to wit: OLSON, through Chappy's Golden Shores obtained $157,496.11 from

the Minnesota Department of Human Services and Medica, by billing for services to Medicaid recipients that were not eligible for reimbursement, of which $142,661.79 was obtained by billing for services provided at an unlicensed facility, and $14,834.32 was obtained by billing for services that were not provided because a Chappy's resident was not at the facility.

COUNT V

Charge: Theft by Swindle (over $5,000)
Minnesota Statute: 609.52.2(a)(4), with reference to: 609.52.3(2)
Maximum Sentence: Imprisonment of not more than 10 years, or payment of a fine of not more than $20,000, or both.
Offense Level: Felony

Offense Date (on or about): 02/07/2017 to 08/06/2017

Control #(ICR#): 20190019

Charge Description: On or about February 7, 2017 through August 6, 2017, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975) obtained property from another person by swindling, whether by artifice or trick, device, or any other means, and the value of the property obtained was over $5,000, to wit: OLSON obtained $8,781.86 from the Minnesota Department of Human Services and Medica, by billing for services to Medicaid recipients that were not eligible for reimbursement, of which $8,781.86 was obtained by billing for services that were not provided because a Chappy's resident was not at the facility.

COUNT VI

Charge: Manslaughter in the Second Degree
Minnesota Statute: 609.205(1)
Maximum Sentence: Imprisonment of not more than 10 years, or payment of a fine of not more than $20,000, or both.
Offense Level: Felony

Offense Date (on or about): 09/24/2018 to 10/06/2018

Control #(ICR#): 20190019

Charge Description: On or about September 24, 2018 through October 6, 2018 in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975) caused the death of another, R.M., by OLSON's culpable negligence whereby OLSON created an unreasonable risk, and consciously took the chance of causing death or great bodily harm to another, R.M., to wit: While operating Chappy's Golden Shores, OLSON, through her own culpable negligence, did not provide R.M. with proper care, following his discharge from hospice, for R.M.'s dysphagia, aspiration pneumonia, transferring, and catheter care, and as a result R.M. died of conditions including septic shock, dysphagia, aspiration pneumonia, and complications from a urinary tract infection.

COUNT VII

Charge: Criminal Neglect of a Vulnerable Adult - Deprivation
Minnesota Statute: 609.233.1a(1), with reference to: 609.233.3(1)
Maximum Sentence: Imprisonment of not more than 10 years, or payment of a fine of not more than $10,000, or both.
Offense Level: Felony

Offense Date (on or about): 08/15/2018 to 10/06/2018

Control #(ICR#): 20190019

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Charge Description: On or about August 15, 2018 through October 6, 2018 in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975) intentionally deprived a vulnerable adult, R.M., of necessary food, clothing, shelter, health care, or supervision, when OLSON was reasonably able to make the necessary provisions, and OLSON knew or had reason to know the deprivation could likely result in substantial bodily harm or great bodily harm to the vulnerable adult, R.M., and OLSON's conduct resulted in great bodily harm to the vulnerable adult, R.M., to wit: OLSON, as operator of and caregiver at Chappy's Golden Shores, did not provide R.M. with proper food or health care for his dysphagia and aspiration pneumonia, did not provide R.M. with proper health care by failing to appropriately reposition him which led to R.M. developing a 25 cm x 25 cm coccyx wound that became septic, did not provide R.M. with proper health care by failing to properly clean and empty his catheter which resulted in a urinary tract infection, and this deprivation resulted in R.M.'s death.

COUNT VIII

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 08/15/2018 to 10/06/2018

Control #(ICR#): 20190019

Charge Description: On or about August 15, 2018 through October 6, 2018 in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975) knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, R.M., to wit: OLSON, as operator of and caregiver at Chappy's Golden Shores, did not provide R.M. with proper food or health care for his dysphagia and aspiration pneumonia, did not provide R.M. with proper health care by failing to appropriately reposition him which led to R.M. developing a 25 cm x 25 cm coccyx wound that became septic, did not provide R.M. with proper health care by failing to properly clean and empty his catheter which resulted in a urinary tract infection.

COUNT IX

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 12/06/2018

Control #(ICR#): 20190019

Charge Description: On or about December 6, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975) knowingly permitted conditions to exist that resulted in the neglect of a vulnerable adult, K.P., to wit: After being told of K.P.'s injuries from a fall, OLSON knowingly failed to provide K.P. with necessary health care when she did not call for an ambulance or otherwise seek medical attention for K.P., whose injuries included a broken hip.

COUNT X

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000,

or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 09/10/2018

Control #(ICR#): 20190019

Charge Description: On or about September 10, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, S.N., to wit: OLSON knowingly failed to provide S.N. with necessary health care when OLSON did not request emergency services for S.N. despite being told of medical conditions indicating S.N. was having a stroke.

COUNT XI

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 06/18/2018 to 11/06/2018

Control #(ICR#): 20190019

Charge Description: On or about June 18, 2018 through November 6, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, S.N., to wit: OLSON knowingly failed to provide S.N. with necessary health care and supervision when OLSON did not have a registered nurse on staff, as is required by law, to conduct any assessments of S.N. or provide any treatment to S.N. the entire time S.N. resided at Chappy's from June, 18, 2018 until his death on November 6, 2018.

COUNT XII

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 07/16/2016 to 12/08/2018

Control #(ICR#): 20190019

Charge Description: On or about July 16, 2016 through December 8, 2018 in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, E.W., to wit: OLSON knowingly failed to provide E.W. with necessary health care when she did not arrange for timely medication administration and caused E.W. to go days without necessary medications, and did not ensure E.W. had timely, necessary catheter cleaning and changes.

COUNT XIII

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

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Offense Date (on or about): 06/05/2018 to 12/06/2018

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Charge Description: On or about June 5, 2018 through December 6, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, E.L., to wit: OLSON knowingly failed to provide E.L. with necessary shelter when she knowingly housed E.L. in an unlicensed facility in a room that had a hole in the closet to the outside of the residence, a broken window, mouse nests in drawers, and animal feces in dressers, floors, and bedding.

COUNT XIV

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 05/09/2018 to 08/05/2018

Control #(ICR#): 20190019

Charge Description: On or about May 9, 2018 through August 5, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, M.B., to wit: OLSON knowingly failed to provide M.B. with necessary supervision when she permitted M.B., who suffered from chronic alcoholism, to have an alcoholic drink in the morning and evening and failed to keep alcoholic bottles and beverages locked and inaccessible from M.B.

COUNT XV

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 12/19/2017 to 12/06/2018

Control #(ICR#): 20190019

Charge Description: On or about December 19, 2017 through December 6, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, E.T., to wit: OLSON knowingly failed to provide E.T. with necessary supervision when she permitted and encouraged E.T., whose service plan stated he was not to have alcohol and whose medications specified they were not to be combined with alcohol, to consume alcoholic beverages at Chappy's, including those that she and Chappy's staff purchased for or provided to E.T.

COUNT XVI

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

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Offense Date (on or about): 06/22/2018 to 12/06/2018

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Charge Description: On or about June 22, 2018 through December 6, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, A.L, to wit: OLSON knowingly failed to provide A.L. with necessary health care when OLSON did not ensure A.L. received an intake assessment or any statutorily required care from a registered nurse during the time he resided at Chappy's.

COUNT XVII

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 09/13/2018 to 12/06/2018

Control #(ICR#): 20190019

Charge Description: On or about September 13, 2018 through December 6, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, R.A., to wit: OLSON knowingly failed to provide R.A. with necessary health care when OLSON did not ensure R.A. received an intake assessment or any statutorily required care from a registered nurse during the time he resided at Chappy's.

COUNT XVIII

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 05/09/2018 to 08/05/2018

Control #(ICR#): 20190019

Charge Description: On or about May 9, 2018 through August 5, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, M.B., to wit: OLSON knowingly failed to provide M.B. with necessary health care when OLSON did not ensure M.B. received an intake assessment or any statutorily required care from a registered nurse during the time he resided at Chappy's.

COUNT XIX

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 08/06/2018 to 12/06/2018

Control #(ICR#): 20190019

Charge Description: On or about August 6, 2018 through December 6, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, D.M., to wit: OLSON knowingly failed to provide D.M. with necessary health care when OLSON did not ensure D.M. received an intake assessment or any statutorily required care from a registered nurse during the time he resided at Chappy's.

COUNT XX

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 04/16/2018 to 12/06/2018

Control #(ICR#): 20190019

Charge Description: On or about April 16, 2018 through December 6, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, J.M., to wit: OLSON knowingly failed to provide J.M. with necessary health care when OLSON did not ensure J.M. received an intake assessment or any statutorily required care from a registered nurse during the time he resided at Chappy's.

COUNT XXI

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 04/21/2018 to 12/06/2018

Control #(ICR#): 20190019

Charge Description: On or about April 21, 2018 through December 6, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, L.S., to wit: OLSON knowingly failed to provide L.S. with necessary health care when OLSON did not ensure L.S. received an intake assessment or any statutorily required care from a registered nurse during the time he resided at Chappy's.

COUNT XXII

Charge: Criminal Neglect of a Vulnerable Adult
Minnesota Statute: 609.233.1
Maximum Sentence: Imprisonment of not more than 1 year, or payment of a fine of not more than $3,000, or both.
Offense Level: Gross Misdemeanor

Offense Date (on or about): 10/01/2018 to 12/06/2018

Control #(ICR#): 20190019

Charge Description: On or about October 1, 2018 through December 6, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), knowingly permitted conditions to exist that resulted in the abuse or neglect of a vulnerable adult, C.S., to wit: OLSON knowingly failed to provide C.S. with necessary health care when OLSON did not ensure C.S. received an intake assessment or any

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statutorily required care from a registered nurse during the time he resided at Chappy's.

COUNT XXIII

Charge: Aiding An Offender - Obstructing Investigation
Minnesota Statute: 609.495.3
Maximum Sentence: Imprisonment of not more than 5 years, or payment of a fine of not more than $10,000, or both.
Offense Level: Felony

Offense Date (on or about): 10/07/2018 to 09/01/2019

Control #(ICR#): 20190019

Charge Description: On or about October 7, 2018 through September 1, 2019, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), intentionally aided another person whom OLSON knew or had reason to know had committed a criminal act, by destroying or concealing evidence of that crime, providing false or misleading information about that crime, receiving the proceeds of that crime, or otherwise obstructing the investigation or prosecution of that crime, to wit: After receiving notice of an investigation into Chappy's, OLSON falsified documents and directed Chappy's employees to falsify documents and provide false and misleading information to investigators, and otherwise obstructed the investigation, into R.M.'s death, which was an investigation into the criminal act of second degree manslaughter.

COUNT XXIV

Charge: Concealing Criminal Proceeds
Minnesota Statute: 609.496.1, with reference to: 609.496.2
Maximum Sentence: Imprisonment of not more than 10 years, or payment of a fine of not more than $100,000, or both.
Offense Level: Felony

Offense Date (on or about): 12/07/2018

Control #(ICR#): 20190019

Charge Description: On or about December 7, 2018, in Aitkin County, State of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), conducted a transaction involving a monetary instrument with a value exceeding $5,000, knowing or having reason to know the monetary instrument represents the proceeds of a felony offense under Chapter 609, to wit: OLSON and her husband withdrew funds from Chappy's Golden Shores business account and had American Bank of the North issue two cashier's check, each for $869,351.00, one of which was in both OLSON and her husband's name, and the proceeds of these cashier's checks represented the proceeds of the felony theft by swindle described in this complaint.

COUNT XXV

Charge: Operating Without A License
Minnesota Statute: 144A.471.4
Maximum Sentence: Imprisonment of not more than 90 days, or payment of a fine of not more than $1,000, or both.
Offense Level: Misdemeanor

Offense Date (on or about): 12/07/2018 to 09/10/2019

Control #(ICR#): 20190019

Charge Description: On or about December 7, 2018 through September 10, 2019, in Aitkin County, State

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of Minnesota, Defendant THERESA LEE OLSON (dob 12/13/1975), was involved in the management, operation, or control of a facility that provided services to residents without a license it was required to obtain under section 144A.471.

STATEMENT OF PROBABLE CAUSE

The Complainant states that the following facts establish probable cause:

Your affiant, Natalie Seiler, is an investigator with the Medicaid Fraud Control Unit (MFCU) of the Minnesota Attorney General's Office. As an investigator for the MFCU, I investigate allegations of Medicaid fraud, abuse, neglect and financial exploitation of vulnerable adults, and other financial crimes. In this capacity, I, along with MFCU Investigator Kristopher Knodle, served as lead investigators into Chappy's Golden Shores (Chappy's), an assisted living facility in Hill City, Minnesota. MFCU investigators Nicholas Sandquist and Kailee Potocnik also played significant roles in the investigation.

During the course of the investigation, MFCU investigators obtained over one million pages of documentary and digital evidence through subpoenas and judicially authorized search warrants on Chappy's premises, financial accounts, email and social media accounts, cell phones, computers and other electronics, and medical records. Additionally, the Aitkin County Sheriff's Office, led by Undersheriff Heidi Lenk and Investigators Steve Cook and Sheryl Cook, conducted an investigation and supported the MFCU investigation. The Minnesota Department of Health (MDH) also investigated Chappy's. All of these entities conducted numerous interviews; for example, MFCU investigators and the Aitkin County Sheriff's Office conducted, between the two of them, close to 100 interviews with former Chappy's residents and employees, medical professionals, social workers, and other witnesses. Assisting law enforcement agencies included the Minnesota Bureau of Criminal Apprehension, Hill City Police Department, and Itasca County Sheriff's Office.

I determined that THERESA LEE OLSON (dob 12/13/1975) (OLSON) and her co-defendants fraudulently provided, supervised, billed, and received payment for, $2,170,384.44 in services from DHS and Medica that were not eligible for reimbursement from the Medicaid program. This fraud fell into four broad categories, as follows:

- Billing the Medicaid program for services that were not eligible for reimbursement because Chappy's had no registered nurse on staff as required by Minnesota law. Chappy's received $528,621.84 as a result of this fraudulent conduct.
- Billing the Medicaid program for services that were provided at an unlicensed, unapproved facility. Chappy's received $616,686.55 as a result of this fraudulent conduct.
- Billing the Medicaid program for services provided by employees who had not passed a statutorily-required background check and in some cases, for services provided by employees who would not have passed a background check due to criminal histories. Chappy's received $989,760.70 as a result of this fraudulent conduct.
- Billing the Medicaid program for services that could not have been provided because the resident was not at Chappy's on the dates billed. Chappy's received $42,259.87 as a result of this fraudulent conduct.

OLSON and her co-defendants also subjected multiple residents to neglect. R.M. a 72 year old Marine Corps veteran who resided at Chappy's, died in October 2018 of septic shock, an untreated UTI, and complications from dysphagia and pneumonia which resulted from improper care, failure to follow doctor's orders, and neglect. K.P., S.N., E.W., E.L., E.T., and M.B. also suffered from neglect at Chappy's. Finally, seven residents never received an RN intake assessment, in violation of Minnesota law, nor did they ever receive a visit from an RN during their time at Chappy's.

Shortly after Chappy's license was suspended due to substantiated allegations of abuse and neglect, OLSON sold Chappy's to her daughter, co-defendant MONIKA LYNN OLSON (dob 1/31/1997) (MONIKA) for $1. MONIKA then attempted to obtain a MDH-issued comprehensive home care license for the facility,

renamed "Mont Royal," which continued to house Chappy's residents receiving unlicensed services from Chappy's employees. MONIKA failed to disclose to MDH that OLSON planned to own and/or manage Mont Royal. Further, in June of 2018, OLSON submitted an application to MDH for Chappy's to provide housing services at the Mont Royal address she sold to MONIKA and allegedly had nothing to do with.

As detailed below, witness interviews, documentary, and digital evidence demonstrated an extensive and coordinated effort by Chappy's owners, management, and employees, including OLSON and her co-defendants, to falsify records in response to the State's investigations and convince potential witnesses to provide false or misleading answers to investigators. This included falsifying documents related to R.M.'s care and directing Chappy's employees to provide untruthful responses to the investigators responsible for investigating R.M.'s death.

I. BACKGROUND ON CHAPPY'S AND THE DEFENDANTS.

A. Chappy's.

Chappy's has been operating in the Hill City area for over 20 years. For the majority of its existence, both Keith Michael Olson and OLSON were involved in the management and day-to-day operations of Chappy's. OLSON was listed as the biller for Chappy's as far back as the late 1990's. In 2016, Keith's medical condition deteriorated, and OLSON took over all of Chappy's operations, although evidence obtained during the investigation suggests that OLSON undertook primary management of Chappy's at least as far back as 2015.

OLSON submitted paperwork to the Minnesota Department of Human Services (DHS) and MDH showing that she was the sole owner of Chappy's as of April 17, 2017. OLSON also identified herself as Chappy's Medicaid biller and a managing employee. LISA MICHELLE ANDERSON, OLSON's sister, was listed as Chappy's only other managing employee, and Michelle Pagan was listed as Chappy's RN. OLSON never disclosed, to DHS or MDH, any other RN or managing employees associated with Chappy's.

Each Medicaid provider receives a unique provider identification number to bill the DHS for services provided. In 2017, Chappy's received two new provider numbers to bill under the version of Chappy's that was fully owned and operated by OLSON.

Chappy's provided customized living services (CLS), adult foster care (AFC), and habilitation services to Medicaid recipients. To provide these services, Chappy's was required to apply for and receive a comprehensive home care license (license) from MDH and enroll with the DHS as a Medicaid provider. Chappy's held a license from MDH until it was suspended on December 6, 2018.

Chappy's submitted its Medicaid claims electronically. As required by the Medicaid program, Chappy's used Current Procedural Terminology (CPT) codes to bill for AFC, CLS services, and habilitation services. These services were required to be billed by the day, i.e., Chappy's billed for each day a resident resided at its facility for a portion of that day. Chappy's then received reimbursement via direct deposit of Medicaid funds. Neither DHS, nor Medica, which provides managed care to certain Medicaid recipients, has the ability to ensure that reimbursable services were provided before making payment.

CLS are provided to Medicaid recipients through the Community Access for Disability Inclusion (CADI) and Elderly waiver programs. To be CADI-eligible, a recipient must be eligible for Medicaid, under 65 at the time of opening of the waiver, certified as disabled, determined to need a nursing facility level of care, and have an assessed need for support and services above those available through a State Medicaid plan. The Elderly waiver program, which is also funded by Medicaid, functions similarly to the CADI waiver program but is reserved for individuals over 65. These waiver programs thus allow recipients to live in the

community, and have their needs met in this setting, rather than reside in a nursing facility. CLS include assistance with: (1) activities of daily living (ADLs) such as eating, bathing, continence care, positioning, and transferring, (2) mental health, cognitive, or behavioral concerns, (3) health-related tasks such as medication set up or reminders, (4) home management tasks such as arranging medication and housekeeping, (5) non-medical transportation, and (6) socialization.

AFC is a type of housing for seniors and persons with disabilities who need some daily care, but do not need skilled nursing care. AFC facilities provide services such as food, lodging, protection, supervision, and household services. Pursuant to Medicaid program regulations, CLS and AFC recipients cannot reside at the same facility.

Habilitation services develop and maintain life skills for people with developmental disabilities or related conditions so that they can fully participate in community life. They may include training, supervision, and support in the areas of, for instance, self-care, independent living, community access, and work related skills training.

On a per resident basis, Chappy's received an average of approximately $341.00 per day in reimbursement for AFC (CPT code S5140), $380.00 per day for CLS (CPT code T2031), and $416.00 for Habilitation services (CPT code T2016).

B. The Defendants' Roles in Chappy's Criminal Enterprise.

OLSON served as Chappy's sole owner and designated Medicaid biller during the charging period. OLSON is a licensed practical nurse (LPN). OLSON was in charge of all business, personnel, financial and medical decisions at Chappy's and its successor entity, Mont Royal. OLSON supervised Chappy's employees, directed their treatment of residents, and decided when residents' conditions required medical attention. OLSON, through Chappy's and acting in concert with MONIKA, ANDERSON, MATTSON-OLSON, and SWANSON, defrauded the Medicaid program of $2,170,384.44. OLSON intentionally failed to provide certain residents with proper medical care and engaged in other instances of patient neglect as further described in this complaint. OLSON further directed employees to falsify documents and provide false statements to investigators who were investigating fraud, theft, abuse and neglect allegations, including R.M.'s death. OLSON directed Mont Royal, which was owned by OLSON's daughter on paper. The day after MDH's onsite visit, OLSON and her husband, Keith Olson, withdrew two cashier's check, each valued at $869,351.00 for a total of over $1.7 million, from Chappy's bank account which consisted of funds that were fraudulently obtained from the Medicaid program.

MONIKA LYNN OLSON (dob 1/31/1997) (MONIKA) is a LPN and OLSON's daughter. Witnesses described MONIKA as being responsible for health care related activities at Chappy's, such as refilling patient medications, assessing patients, and administering medications. MONIKA also constructed worker schedules and, along with OLSON, billed DHS for services that were ineligible for reimbursement. She helped OLSON hire new employees and assisted OLSON with payroll. Following MDH's suspension of Chappy's license, MONIKA attempted to obtain a license for a new facility, Mont Royal, at the same address as Chappy's; in her application to MDH, MONIKA listed Pagan as the RN for Mont Royal despite Pagan not agreeing to work there. MONIKA assisted OLSON in directing efforts to falsify medical documents and personnel records and provided false information in response state investigations into Chappy's. She personally falsified certain medical records, including R.M.'s medical records, and provided false testimony about Mont Royal's provision of medical services during a civil court proceeding in Aitkin County.

LISA MICHELLE ANDERSON (dob 3/12/1973) (ANDERSON), OLSON's sister, served as Chappy's managing employee for all Chappy's locations during the charged dates of offense. Her duties as

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managing employee included, but were not limited to, hiring workers and helping to recruit new clients. ANDERSON also conducted health care related activities for Chappy's, including intake assessments for new recipients, despite ANDERSON not being a RN or having any other nursing credentials. ANDERSON also scheduled appointments, helped obtain resident medications, and scheduled medical transportation for Chappy's residents. In 2018, ANDERSON received $207,633.00 in checks from Chappy's; according to former employees, part of ANDERSON's pay included "client bonuses." ANDERSON was involved in similar management and health care related activities at Mont Royal. For example, records obtained from Medical Transportation providers showed ANDERSON arranging medical transportation services for J.A. while he lived at Mont Royal. During state investigations, ANDERSON instructed Chappy's employees to avoid speaking with law enforcement and instructed former HHA Ashley Poirier to hide her phone so that it could not be seized during a search warrant at Chappy's.

BENJIMAN HOWARD SWANSON (dob 4/18/1981) (SWANSON), who is the father of one of OLSON's children, served in a variety of roles at Chappy's. SWANSON acknowledged beginning to work as a HHA at Chappy's in 2015, despite not being submitted for a background study until September 1, 2016. SWANSON provided direct care to recipients, including transportation and medication dispensation. He resided at Chappy's during the charging period and remained onsite to help manage Mont Royal after Chappy's license was suspended by MDH. SWANSON provided direct contact services to Mont Royal residents, including assisting with medications, despite Mont Royal not having a license to do so. SWANSON helped falsify documents and cover up Chappy's criminal activity. During MDH's November 6, 2018 onsite at Chappy's, SWANSON instructed B.W., who had not passed a background study, to hide downstairs and lock a room that contained Chappy's personnel records. SWANSON also "purchased" one of Chappy's buildings for $1 after MDH began investigating the facility. In 2018, Chappy's issued $71,892.01 in checks to SWANSON.

JANIECE FREELOVE MATTSON-OLSON (dob 3/27/1993) (MATTSON-OLSON), OLSON's niece, worked as a HHA at Chappy's. She also supervised certain employees, helped recruit new clients, and accompanied residents, including S.N., to the hospital to receive care. MATTSON-OLSON also provided services after Chappy's license suspension, both at Mont Royal and at her own residence, where multiple former Chappy's residents temporarily resided and received services, including medication management, from MATTSON-OLSON and other former Chappy's employees. MATTSON-OLSON helped construct client "books" and nursing notes in response to MDH's investigation, and her signature frequently appeared on health records which were inconsistent with Chappy's calendars and employee schedules. Finally, MATTSON-OLSON assaulted Chappy's resident P.A. in October 2018.

KRISTIN MARIE DAVIS (dob 3/19/1986) (DAVIS), ALEXCIS ELIZABETH HINES (dob 8/16/2000) (HINES), CHRISTINA MICHELLE MEAGHER (dob 12/21/1989) (MEAGHER), and SUSAN JOYCE ELLIS (dob 2/16/1981) (ELLIS) worked at Chappy's as HHAs. After Chappy's license was suspended, HINES and MEAGHER continued to provide services to residents at Mont Royal. HINES also provided services at MATTSON-OLSON's house in January 2019. GEORGIA LOUISE SALOMONSON (dob 12/22/1971) (SALOMONSON) worked at Chappy's as an HHA in 2017 and 2018 and was one of R.M.'s primary caregivers.

DAVIS, HINES, MEAGHER, ELLIS and SALOMONSON obstructed the State's investigation by falsifying documents. SALOMONSON and ELLIS also lied about R.M.'s care during the State's investigation into a second degree manslaughter charge, a crime of violence. DAVIS admitted to MFCU investigators that she created health records for R.M. on dates that Chappy's schedules show she was not working.

II. CHAPPY'S FRAUD AGAINST THE MEDICAID PROGRAM.

A. Requirements by DHS and MDH For Services Provided By Chappy's.

To be eligible for reimbursement from the Medicaid program, services provided by Chappy's must meet standards contained in the license issued by the MDH and codified in Minnesota law as meeting the standards of the Medicaid program. For purposes of this case, most relevant are provisions requiring Chappy's to have a registered nurse (RN) on staff, provide services only in sites specifically licensed by the MDH, and have services provided by individuals who passed a background study conducted by the DHS and were approved to provide direct contact services to recipients.

Specifically, Chappy's was required to have an RN on staff, affiliated with the site, at all times to comply with its 245D comprehensive home care license issued by MDH. Chappy's also obtained a license under Minn. Stat. Chapter 144A. When a provider like Chappy's first enrolls with the MDH, it must list an RN on its license application. The provider must maintain an RN on staff at all times; in other words, if the RN leaves, Chappy's must replace the RN. When providers like Chappy's submit their annual license renewal, they must list the facility's RN on the license. MDH will not issue or renew a license if an RN is not listed on the license and on staff at the facility. DHS will not pay for any Medicaid-funded services if a facility does not meet the MDH standards for a comprehensive home care license, or if MDH would not allow a facility like Chappy's to operate, or continue operating, if the facility was not appropriately staffed and supervised by a RN.

When MDH issues a comprehensive home care license to a facility like Chappy's, it licenses a specific physical location. The license only applies to this explicitly defined location. On the license appears the message: "Not transferable as to Registrant or Location."

For the protection of vulnerable recipients, Medicaid providers, like Chappy's, must submit every employee who provides direct contact services to Medicaid recipients for a background study to DHS. DHS then determines whether the individual has any prior criminal convictions or other conduct that disqualifies them from providing direct contact services. DHS will explicitly notify providers, like Chappy's, whether an individual has passed a background study. Prior to passing a background study, the individual may not provide direct contact services, except in very limited circumstances and subject to appropriate supervision. Any services provided by individuals who have not passed or have not been submitted for a background study are ineligible for reimbursement from the Medicaid program.

Medicaid providers like Chappy's can only bill for services actually provided. Providers like Chappy's bill a daily or monthly code. Chappy's billed a daily code for each individual at the facility; in other words, to bill, Chappy's biller – listed as OLSON – will manually enter each individual date and resident into DHS's billing program and submit the claim.

Providers billing a daily code cannot bill for days when a resident is out of the facility for an entire day. For example, if a resident leaves Chappy's at 6 P.M. on Friday and does not return until 10 A.M. on Sunday, Chappy's cannot bill for the Saturday that the resident was not at the facility.

B. Chappy's Fraudulently Billed and Received Over $2.1 Million in Medicaid Funds.

Chappy's billed, and received reimbursement for, $2,170,384.44 in services that were not eligible for reimbursement from the Medicaid program. At all times during this case's charging period, DHS provider enrollment documents listed OLSON as Chappy's designated biller.

1. Chappy's Unlawfully Billed For Services Without A Registered Nurse on Staff.

During the charging period, Chappy's only RN on staff was Michelle Pagan. On its MDH license application, Chappy's only disclosed Pagan, and all witness interviews mentioned Pagan as the only RN –

if the witnesses could even identify a nurse at all. On April 4, 2018, Pagan sent a letter to OLSON informing her that Pagan was resigning from Chappy's because she felt that she could not care for Chappy's high needs clients. Pagan said her last day would be May 4, 2018. Pagan did not provide any care to Chappy's residents after this date.

Chappy's did not hire any other RN after Pagan quit. Instead, Chappy's continued to list Pagan as its RN on license applications and other correspondence. On June 11, 2018, OLSON submitted Chappy's required license renewal application. OLSON listed Pagan as the RN at Chappy's, despite Pagan resigning from Chappy's over a month earlier. No other RN was listed, and there is no record of another RN being paid by or affiliated with Chappy's after Pagan resigned. On September 8, 2018, MDH approved Chappy's license based on OLSON's representation that Chappy's had Pagan working as a RN; without a RN on the application, Chappy's would not have received a license and would not have been able to continue billing DHS for Medicaid-funded services.

The MFCU interviewed Pagan three times and each time, Pagan stated that she did not work at Chappy's after her resignation, she did not know OLSON listed her as Chappy's RN on the renewal application filed in June 2018, and that she would not have approved of OLSON listing her on the application. Pagan said that following her resignation, her agreement with OLSON was to provide a monthly training for new employees. Pagan said whenever she went to Chappy's, she walked in, conducted a training in the main room for new employees, and walked out without doing any client work. Pagan said she did not perform any RN duties, such as client intakes, change of care forms, medication management services, or 90-day assessments, at Chappy's after her resignation date.

I showed Pagan intake assessments and client service plans in Chappy's client files that were dated after Pagan's last day. These documents purportedly contained Pagan's signature. Pagan said she did not conduct these assessments, which are required by statute to be completed by a RN. Witness interviews described the assessments as being completed by OLSON, ANDERSON, or MONIKA. For example, Chappy's resident E.L., who lived at the "top house," stated her intake forms were completed by ANDERSON even though they contained Pagan's signature. Pagan confirmed she did not sign these forms or assess E.L.

According to Pagan's text message history, prior to her resignation, Pagan corresponded with OLSON about Chappy's-related activities, outside of trainings Pagan did for employees. After Pagan's resignation, she messaged with OLSON and other Chappy's employees much less frequently. When she did message with them, the messages did not relate to Chappy's clients' medical needs.

Numerous former Chappy's employees told MFCU investigators they received inadequate or no training from a nurse at Chappy's. Certified nursing assistant (CNA) Madison Amundson (Amundson), who worked at Chappy's from August 2018 through December 3, 2018, stated she received no training from any nurse upon starting. This was concerning to Amundson because some of the residents she cared for had significant mental health issues and she did not know how to care for them because she received no training and had no experience serving clients with these mental health needs. When I asked Amundson about training on resident falls, she stated she never received any training on the topic and would not have known what to do had a resident fallen at Chappy's. I showed Amundson records from her employee file, including documentation of training provided by Pagan. Amundson said she did not receive this training and the signatures on documents were not hers. Amundson said that after MDH's onsite, MATTSON-OLSON requested that she batch sign documents for her employee file and Amundson refused.

Chappy's CNAs who worked at other facilities after leaving Chappy's described significant differences in the RN's role at the facility. For example, Ailie Bailey (Bailey), a former CNA at Chappy's, reported that she saw a nurse at Chappy's approximately 8 times in the five years she worked at Chappy's. Bailey estimated that within four days at her new facility, she saw a RN eight times. Amundson said that at her new job, RNs

handled wound care and catheter changes for residents, while at Chappy's, untrained CNAs were largely responsible for these tasks.

Former Chappy's residents also said they did not receive care from a nurse. R.T. stated that Pagan came to the facility once per month. E.W. stated that he did not receive proper services from Pagan while she worked there. Other residents did not recognize Pagan as being Chappy's nurse, and instead described the nurse as either OLSON or MONIKA. Additionally, R.M.'s hospice care nurses from Grand Itasca did not recognize Pagan and said they never spoke with her. The hospice care nurses further stated that when they needed to speak to a "nurse" they spoke with OLSON.

MDH would not have licensed or continued to license Chappy's without a RN on staff. DHS paid out $524,159.79 in Medicaid funds after September 8, 2018, when MDH issued Chappy's renewed licensed based on OLSON's false assertion that Pagan was Chappy's RN. Medica paid out $4,462.05 in Medicaid funds after this date. DHS and Medica would not have reimbursed these services if Chappy's did not have an RN on staff and a properly issued license by MDH.

2. Chappy's Unlawfully Billed For Services At An Unlicensed, Unapproved Facility.

Chappy's also received reimbursement for services that it provided outside of a licensed facility. Chappy's MDH license listed its main facilities located at 530 and 540 Park Avenue in Hill City. The license explicitly stated: "Not transferable as to Registrant or Location."

Chappy's housed residents E.L., T.H., D.M., L.S., and M.S. at 600 Summit Avenue in Hill City from the time they moved in until Chappy's shut down. Chappy's employees and residents frequently referred to this address as the "top house" or "upper house." Chappy's license from MDH did not cover this location, and any comprehensive health services provided at this unlicensed location were not eligible for reimbursement from DHS or Medica. Chappy's was also not permitted to house AFC and CLS residents in the same facility.

Shauna Kasper, a guardian and conservator for multiple Chappy's residents, stated that when she visited Chappy's, C.S. and M.S., two of her clients, resided at the top house. Further, on October 3, 2018, Itasca County Social Worker Heidi French reported to DHS that her client, E.L., had resided at a different address from the one Chappy's listed since E.L. moved to Chappy's on March 2, 2018. French told DHS she believed this address was not licensed and that this was "fraudulent behavior."

Employees, including former Chappy's HHAs Bailey, Amundson, Shaye Edwall and Rose Palkki (Palkki) also reported that Chappy's residents lived at this unlicensed location. Palkki mentioned N.W. working at the top house; N.W. has a prior conviction for electronic solicitation of a minor and would not have passed a background study.

Chappy's resident E.L. told me she lived at the top house, as did resident R.T. who stated other top house residents included E.L., D.M., and L.S. Consistent with their statements, a notebook titled top house seized during execution of a search warrant at Chappy's included records of services provided to E.L., R.T., D.M., and L.S.

OLSON and MONIKA regularly communicated via text message about services and personnel issues at the top house. Marie Skelly, a former Chappy's HHA, stated that OLSON told Skelly not to speak to anyone from the State about the "top house." In a November 9, 2018 email sent from OLSON to Michelle Leitinger of Aitkin County Environmental Services, OLSON stated that all residents living at the top house were private pay clients. To the contrary, OLSON, through Chappy's, received over $600,000.00 by billing for services provided to Medicaid recipients residing at this unlicensed facility.

Certain co-defendants actively assisted OLSON in the provision of unlicensed services at the top house. As discussed above, ANDERSON was the managing employee for all of Chappy's facilities, including the top house. SWANSON helped ANDERSON and OLSON manage the top house, and owned the top house on paper, after OLSON transferred it to him for $1 when MDH began investigating Chappy's. MONIKA helped schedule workers for the top house, provided services to residents at the top house, passed out paychecks for services provided at the top house, and undertook efforts to conceal the identity of HHAs who had not passed background studies yet were allowed to work at Chappy's, including the top house.

MATTSON-OLSON signed nursing notes and daily care sheets indicating she provided services to residents who lived at the top house, including T.H. and M.S. Residents and former workers described MATTSON-OLSON as providing services at the "top house." Further, during a search warrant at MATTSON-OLSON's residence, the MFCU seized medication-related documents for top house residents T.H. and J.M., and mail addressed to top house resident E.L.

Chappy's license from MDH did not cover any services provided at this unlicensed location. DHS and Medica would not have reimbursed any Medicaid services provided at an unlicensed facility. After warrant date August 7, 2017, DHS paid out $616,686.55 for services to residents E.L., T.H., D.M., L.S., and M.S. that were not covered because the services were provided at an unlicensed facility.

3. Chappy's Billed The Medicaid Program For Unapproved HHAs.

Before any individual can provide direct contact services to Medicaid recipients, Minnesota law requires that the individual be submitted by the enrolled agency, like Chappy's, to DHS for a background study. DHS will then complete a background study and notify the agency if the individual is approved to provide services. In the time between when the individual is submitted for a background study and when the employer receives notification of the results, the employee cannot provide direct contact services except in very limited circumstances, such as under direct supervision at all times from another employee.

Chappy's routinely employed HHAs to provide direct contact to Medicaid recipients without submitting them for a background study. At other times, Chappy's allowed HHAs to continue to provide direct care to vulnerable Medicaid recipients after learning that they had not passed DHS's background study.

Like all enrolled Medicaid providers, OLSON received notice from DHS each time an individual either did or did not pass a background study. Even after receiving notice that a HHA did not pass a background study, OLSON would continue to employ them in positions where they provided direct contact services. For example, OLSON received notice on June 5, 2017 that C.A. did not pass a background study and that OLSON's request for an exception to the disqualification was denied by DHS. OLSON continued to employ C.A. as a HHA providing services to Chappy's residents and paid her for this work.

Some Chappy's HHAs may have passed a background study when they began at Chappy's, but while working at Chappy's, committed criminal offenses that would have disqualified them from providing direct contact services. For example, D.B. passed a background study but was then charged and convicted of gross misdemeanor fourth degree assault on a peace officer in 2016. When OLSON took over Chappy's in 2017 and received a new NPI number from DHS, she was obligated to submit all current employees for a background study, even if Chappy's had done so under previous ownership. Had OLSON submitted D.B. for a background study in 2017 as required, D.B. would not have passed because a gross misdemeanor fourth degree assault conviction is a disqualifying crime. OLSON, however, never submitted D.B. for a background study when she took over. Minnesota law required an individual who commits a disqualifying offense to be removed from direct contact with residents.

While OLSON's attorney was present in the room, OLSON stated in an interview that HHAs S.E. and S.O.

were two of the HHAs who provided services to S.N., one of the neglect victims in this case. Neither S.E. nor S.O. had passed a DHS background study during the time OLSON described their work at Chappy's, and S.E. would not have passed due to a prior theft conviction. S.E. told me that after Chappy's shut down, she applied for another job as a HHA and was told she was disqualified from providing direct care for 7 years due to her theft conviction.

Some Chappy's workers reported to me that they knew Chappy's was not submitting background studies. Palkki told me that she knew she did not have a background study done because she never received any notice in the mail from DHS saying her background study had been processed. When Palkki raised this issue to senior staff member Jami Passig, Passig responded, "welcome to Chappy's" and told Palkki that OLSON did things her own way. Passig further explained to Palkki that OLSON did not submit background studies for workers she knew would not pass and instead listed these workers as "maintenance" or "custodian" and made sure they were not present for MDH licensing reviews.

I conducted a payroll analysis to determine Chappy's payments, in total, to HHAs, both approved and unapproved, during the charging period and determined Chappy's Medicaid reimbursement during the same time period. After seeing the gross wages paid to its HHAs, I calculated how much of the wages were paid to individuals who were not approved to provide services. I then used this percentage to determine the amount of services ineligible for reimbursement from DHS.

For example, if in a 14-day period, Chappy's paid HHAs a total of $10,000, and $3,000 of those wages went to individuals who had not passed a background study, I determined that 30% of Chappy's services during that time period was provided by unapproved individuals and, thus, ineligible for Medicaid reimbursement. If during this same time period, Chappy's received $15,000 in Medicaid reimbursement, and 30% of those services were provided by individuals not approved to provide direct contact services, then I determined that $4,500 out of the $15,000 (30%) was fraud.

In calculating gross wages to employees, I included all wages, even for management employees like ANDERSON and SWANSON, who spent some, but not all, of their time providing direct contact services to Chappy's residents. ANDERSON earned $207,633.00 and SWANSON earned $71,892.01 in 2018, which was well in excess of what Chappy's HHAs earned. As a result, in my calculations, the gross wages of approved employees was higher – and the percentage of fraudulent wages, i.e., wages paid to non-approved providers lower – than it would have been had I omitted SWANSON and ANDERSON's wages from my calculations.

From warrant dates of February 7, 2018 to February 5, 2019, Chappy's received a total of $3,354,563.61 in Medicaid reimbursement from DHS and Medica. In 2018, Chappy's issued payroll of $1,937,457.56 to workers, $595,554.82 of which were checks issued HHAs who did not pass a statutorily-required background check. Based on 30% of payroll being paid to a person that failed a background study, had a background study that was not completed or did not have a background study ran at all, I found that Chappy's received $989,760.70 in reimbursement for services that were not covered and ineligible for reimbursement.

The dates of payroll checks issued to unapproved workers were consistent with calendars and work schedules seized from Chappy's. For example, OLSON's computer had a calendar of workers for August 2018. Each day had multiple people listed as working who had not passed a background study.

Based on an analysis of who Chappy's wrote checks to, in 2018, prior to Chappy's submitting numerous employees for background studies after it received notice of an MDH investigation in the fall of 2018, Chappy's had 25 employees on staff who had passed background studies. Chappy's had 34 residents during this same time period. Many, such as S.N., required one-on-one care. Chappy's could not have appropriately staffed its facility, with the required number of employees who had passed background

studies, in a manner that would meet its residents' care needs.

MONIKA, ANDERSON, SWANSON, MATTSON-OLSON, and other Chappy's employees undertook extensive efforts to cover up direct care by HHAs who had not passed a background study. They constructed multiple versions of handwritten and electronic calendars, which were often inconsistent with each other, service documentation, and Chappy's payroll. After receiving notice of MDH's investigation, Chappy's routinely altered or rewrote documents to make it appear as if individuals who had passed a background check provided the services, instead of the providers who had not passed a background check.

As just one of many examples, top house resident A.L.'s daily care sheet for September 2, 2018 contained initials "AB" which appeared to have been written over a different set of initials. The bottom of the care sheet, however, was signed by A.F. HHA Ailie Bailey had passed a background study, while HHA A.F. would not have passed a background study had one been submitted due to prior felony convictions.

HHAs HINES and Jennifer Drieman (Drieman) received payroll checks from Chappy's throughout 2018, and both "volunteered" at Mont Royal after Chappy's license was suspended. After Chappy's came under investigation by MDH, HINES and Drieman texted about where OLSON wanted them to go for background studies. After MDH's onsite visit on November 6, 2018, OLSON and other employees altered employee files to make it appear as if the employees started at Chappy's on the same day their background study was submitted, including HINES Drieman, and N.W. In some circumstances, they simply crossed out the employee's real start date and replaced it with a date in November 2018, after MDH's onsite visit. Many of these files with altered dates contained a signature purporting to be Pagan's that was dated after she resigned from Chappy's.

N.W. told me that OLSON instructed him to tell investigators that he did not start working at Chappy's until November 8, 2018. HHA Phylisha Jarvi similarly reported that OLSON told her to the lie to "the State" about her start date if anyone asked. When I showed her records from her personnel file, she confirmed that her signature had been forged on documents that corresponded with a start date nearly a year after she actually started working at Chappy's.

MONIKA indicated in Facebook posts from her account that she knew Chappy's was allowing people to work prior to completing a background study. MONIKA texted with disqualified Chappy's HHAs and told them not to come to Chappy's when MDH investigators were on site. For instance, on November 6, 2018, MONIKA messaged HHA B.W.: "…state is in the house and will be at time of night shift as well. Please come in and go directly to the basement so they don't see you until they are gone." B.W. had not passed a background study, was not approved to provide services to recipients, and had prior felony convictions that would have precluded him from passing a background study. B.W., though, received $16,622.00 in checks from Chappy's in 2018. On November 28, 2018, MONIKA messaged another unapproved HHA: "if state calls you pertaining to chappys you need to tell them you never worked for us, and that you were gonna do a background because you lived at my house and you went to chappys with me all the time." (sic)

DAVIS and SALOMONSON also participated in this fraudulent conduct. In a post on Chappy's private Facebook page, DAVIS instructed Chappy's employees how to answer MDH's questions and provided false start dates of certain employees that coincided with background study dates. When interviewed by MFCU investigators, DAVIS claimed she did this of her own volition and not at OLSON's direction. SALOMONSON told Amundson to tell MDH that certain workers — including SALOMONSON's son who had not passed a background check — did not work at Chappy's.

4. Chappy's Billed The Medicaid Program For Services That Were Not Provided.

On many dates, Chappy's billed, and received reimbursement for, dates when a Chappy's resident was not at Chappy's for an entire day. For instance, Chappy's client file on T.F. indicated T.F. left the facility on September 3 and returned on September 6, 2018. A document, titled "procedures to follow when client leaves for a visit with a family or personal outing" contained a list of medications for T.F. and instructions on when to take them. The form was signed by T.F. and MONIKA on September 3, 2018 and again on September 6, 2018. Based on this documentation, Chappy's could not bill for September 4-5, 2018 because T.F. was absent from the facility all day. Chappy's did, however, bill DHS for these days.

T.F. was also hospitalized from September 26 to October 3, 2018 at Deer River Healthcare. She was then transferred to Essentia Health on October 3 and remained at Essentia until her discharge on October 5, 2018. Chappy's, however, unlawfully billed for services from October 1, 2018 through October 4, 2018 and received $1,368.08 in Medicaid reimbursement.

Teri Dubovich, the mother of Chappy's resident P.A., told Hill City Police Chief Joshua Kimball that since January of 2017, when P.A. moved into Chappy's, Dubovich picked up P.A. every other weekend and had P.A. from Friday around 5 until Sunday around 5. Dubovich further stated that while she did not have exact dates, it was "for the most part" every other weekend. Dubovich noted that in August of 2017 she took P.A. for a week-long vacation to the Black Hills in South Dakota. Dubovich also said that P.A. occasionally stayed at her father's house. In an interview, SWANSON agreed that P.A. left the facility multiple times for three to four days. SWANSON further stated that it was a fair statement to say P.A. was gone from the facility every other weekend.

Chappy's, however, billed DHS for services provided to P.A. every single day from January 4, 2017 through October 24, 2018, including every weekend. Chappy's also billed the entire month of August in 2017 despite Dubovich's statement that P.A. was gone for a week on vacation. Chappy's received $404.90 per day for P.A.'s care.

Based on Dubovich's statement, during the time period P.A. resided at Chappy's, I counted two to three Saturdays per month as overbilled (based on how many Saturdays there were in that month). In addition, I assessed five days of overpayment to August 2017 for P.A.'s vacation with her mother. Using this calculation method, I found Chappy's received $21,056.22 for services while P.A. was not residing on the premises.

In total, between warrant dates of February 7, 2017 and February 5, 2019, Chappy's billed, and was paid for, $42,259.87 in services that were not provided because the residents were not at Chappy's. In 2018, Chappy's also submitted $9,122.26 of claims for services provided to residents who could not have received the services because they were hospitalized at the time. DHS denied these claims before they were paid, so I did not include them in my fraud calculation here.

5. Summary Of Chappy's Medicaid Billing Fraud.

In total, Chappy's received $2,177,328.96 from DHS and Medica by billing for fraudulent services, i.e., services that were not provided and/or were provided without proper supervision, at an unlicensed facility, or by unqualified providers.

DHS and Medica claims data, which show claims for reimbursement submitted by Chappy's, indicate both a service date and a warrant date. A service date is the date the health care services were actually provided by Chappy's. A warrant is the date that DHS or Medica issue payment to Chappy's. Providers like Chappy's are permitted to bill for services up to a year after the date of service, and in this case Chappy's submitted claims, at times, well after the date of service.

I aggregated the amounts into six month periods of time for charging purposes. I did not double count

fraud; i.e. if a claim was fraudulent for more than one reason, I only counted the overpayment once. Chappy's fraud, as calculated by warrant date and based on the above-described schemes, is as follows:

Count	Warrant dates	No RN (DHS)	Unlicensed Facility (DHS)	No BGS (DHS)	Out of Facility (DHS)	Total (DHS)
2	8/1/2018 - 2/5/2019	$524,159.79	$231,043.31	$520,015.47	$9,050.96	$1,284,269.53
3	2/7/2018 - 8-6/2018	$0.00	$236,036.93	$456,826.90	$9,592.73	$702,456.56
4	8/7/2017 - 2/6/2018	$0.00	$142,661.79	$0.00	$14,281.28	$156,943.07
5	2/7/2017 - 8/6/2017	$0.00	$0.00	$0.00	$7,912.56	$7,912.56
Count	**Warrant Dates**	**No RN (Medica)**	**Unlicensed Facility (Medica)**	**No BGS (Medica)**	**Out of Facility (Medica)**	**Total (Medica)**
2	8/1/2018 - 2/5/2019	$4,462.05	$0.00	$6,158.28	$0.00	$10,620.33
3	2/7/2018 - 8-6/2018	$0.00	$0.00	$6,760.05	$0.00	$6,760.05
4	8/7/2017 - 2/6/2018	$0.00	$0.00	$0.00	$553.04	$553.04
5	2/7/2017 - 8/6/2017	$0.00	$0.00	$0.00	$869.30	$869.30
Count	**Warrant Dates**	**Total No RN**	**Total Unlicensed Facility**	**Total No BGS**	**Total Out of Facility**	**Total Fraud**
2	8/1/2018 - 2/5/2019	$528,621.84	$231,043.31	$526,173.75	$9,050.96	$1,294,889.86
3	2/7/2018 - 8-6/2018	$0.00	$236,036.93	$463,586.95	$9,592.73	$709,216.61
4	8/7/2017 - 2/6/2018	$0.00	$142,661.79	$0.00	$14,834.32	$157,496.11
5	2/7/2017 - 8/6/2017	$0.00	$0.00	$0.00	$8,781.86	$8,781.86
All Counts	**Grand Total**	$528,621.84	$609,742.03	$989,760.70	$42,259.87	$2,170,384.44

"BGS" is an abbreviation for background study.

C. Defendants' Attempted To Obtain A Comprehensive Home Care License For Mont Royal And Continued to Provide Services Following Chappy's License Suspension.

1. Defendants' Attempted To Obtain A Comprehensive Home Care License Following Chappy's License Suspension.

After Chappy's comprehensive home care license was suspended in December 2018, the defendants tried to continue operating as a facility on the former Chappy's premises at 540 Park Avenue in Hill City. According to property records, OLSON transferred the Chappy's facility to MONIKA. The facility then

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renamed itself Mont Royal.

Starting in March 2019, MONIKA submitted multiple applications to the MDH to receive a comprehensive home care license for the facility renamed "Mont Royal." As discussed above, MONIKA listed Pagan as Mont Royal's RN, despite Pagan not agreeing to work there.

Even as she represented to MDH that Pagan would be Mont Royal's RN, MONIKA texted multiple people, including Chappy's employees, to ask if they knew of nurses who would work at Mont Royal. For instance, on March 4, 2019, MONIKA asked Pagan for her middle name, which she used on Mont Royal's application to MDH. On the same day, MONIKA asked her fiancé and a former Chappy's HHA if they knew of any RNs who would work at Mont Royal.

MDH twice rejected Mont Royal's application because it was incomplete. Had MONIKA submitted a complete application with Pagan's information as the registered nurse, her application would have been approved and she would have become eligible to provide services to former Chappy's residents and bill the Medicaid program for these services.

2. Defendants Provided Unlicensed Health Care Services To Mont Royal Recipients.

Following the closure of Chappy's, and despite MDH's rejection of Mont Royal's license application, numerous Chappy's residents continued to live at the facility. Many of these residents had previously been approved to receive significant health care services – in some cases, 1-on-1 care and 24-hour per day care – at Chappy's. Chappy's nurses and former employees signed off on care plans and other notes documenting the substantial health care needs of these individuals. According to former Chappy's owners and employees, and an attorney representing Mont Royal, the residents at Mont Royal were not receiving any health care services despite these significant health care needs. I did not find any evidence suggesting that these residents had significant changes in their medical conditions to the point where they no longer needed the amount of care they were authorized to receive at Chappy's.

MONIKA owned Mont Royal on paper, while OLSON, ANDERSON, SWANSON, and MATTSON-OLSON continued in similar roles to those they had at Chappy's. Former Chappy's HHAs, including SWANSON, HINES, Jennifer Drieman, Chase Anderson, and Chance Hendrickson, also resided at Mont Royal and provided health care services to Mont Royal residents despite Mont Royal not having a license to do so.

MONIKA's cell phone included numerous texts with Mont Royal workers discussing work schedules and health services. For example, in December 2018 and January 2019, MONIKA texted with HHA Drieman about work schedules and medical supplies for Chappy's/Mont Royal resident J.J. MONIKA texted with MATTSON-OLSON about picking up a resident's prescriptions on January 5, 2019; at this time, MATTSON-OLSON also had multiple former Chappy's residents living at her house.

MONIKA also communicated with ANDERSON about Mont Royal. On February 8, 2019, ANDERSON left MONIKA a message stating that ANDERSON was picking up medications for a Mont Royal resident.

OLSON was also involved in Mont Royal's business operations. Messages obtained from HINES's phone showed that OLSON called a meeting on May 13, 2019 and that OLSON was present at Mont Royal on May 20, 2019. On July 6, 2019, HINES sent a message saying that "Trish" would not want anyone around [Mont Royal] at the time.

HINES was also involved in the provision of unlicensed medical services at Mont Royal. HINES messaged MATTSON-OLSON on December 30, 2018, asking about J.A.'s medications. On January 10, 2019, HINES and Chase Hendrickson talked about administering medications to J.J., who resided at Mont Royal from the time Chappy's closed until the MFCU executed a premises search warrant on July 8, 2019. On

March 4, 2019, HINES messaged Drieman with instructions on medication administration for Chappy's/Mont Royal residents J.A. and J.M. On May 27, 2019, HINES and Drieman also discussed medication administration to residents. HINES also talked about certain residents needing medical attention. For example, on March 12, 2019, HINES stated Mont Royal resident J.M. may have had an infection and may need to be admitted.

HINES and SWANSON discussed Mont Royal work schedules. For example, on May 13, 2019, HINES and SWANSON talked about the nighttime schedule. HINES also shared Mont Royal's "schedule" with Chase Hendrickson on April 9, 2019 after discussing the schedule with SWANSON.

On July 8, 2019, HINES, DRIEMAN, and SWANSON were all present during a search warrant at Mont Royal. All of them denied that Mont Royal was providing any services to residents. During execution of this search warrant, I seized a handwritten calendar for July 2019. The calendar listed MEAGHER, HINES, Jennifer Froelich, Jennifer Drieman, F.M., and three of SWANSON's children as scheduled that month. F.M. has multiple felony convictions that would prevent her from passing a background study.

On September 11, 2019, I spoke with F.G. after she was hospitalized. F.G. said that she was living at the former Chappy's facility immediately prior to her hospitalization. F.G., who is 98 years old and blind, had a "call button" with her at the hospital that was used while at her residence. F.G. also said that employees bathed her, and that they administered medication to her for a period of time before she started self-administering her numerous medications.

Mont Royal never obtained a comprehensive home care license allowing it to provide services to residents. On July 30, 2019, MONIKA provided sworn testimony at a hearing on a civil case filed in Aitkin County District Court. MONIKA testified that Mont Royal was an apartment complex and did not provide any health care services to residents. Based on the above-described evidence, this sworn statement was false.

III. CHAPPY'S NEGLECT OF RESIDENTS.

Interviews with former employees showed that Chappy's neglected residents in its care after OLSON took over running the business. The former employees described Chappy's as originally being a place that cared for primarily elderly individuals. In the last several years of its operation, Chappy's began housing younger residents with more significant physical and mental health needs that OLSON and her staff were not equipped or trained to handle.

The younger Chappy's residents with significant mental health issues or physical needs carried higher daily reimbursement rates than some of Chappy's older residents. Chappy's reimbursement from DHS and Medica increased from $1,063,868.59 in 2016 to $3,354,563.61 in 2018, when OLSON had largely completed her transition to housing younger patients with higher needs.

Former Chappy's employees described residents' mental health issues as being particularly difficult to deal with in the facility Chappy's had constructed. Pagan said that she resigned from Chappy's because she did not feel capable of caring for, or training workers to care for, individuals with these mental health needs. MONIKA, herself, acknowledged in a text message sent to OLSON on November 28, 2018 that clients with significant mental health issues were "…getting us in trouble."

Residents also described poor conditions at Chappy's. R.T., who resided in both Chappy's main facility and its unlicensed top house, said that "it was a nightmare every day I was there." E.W. said he knew he made a big mistake in agreeing to live at Chappy's as soon as he pulled up. E.L. said she was "200 percent better" since leaving Chappy's.

A. Neglect and Death of R.M.

R.M., a Marine Corps veteran who began residing at Chappy's in 2017, received comprehensive home care services for diagnoses including a traumatic brain injury, pressure ulcers, prior stroke, and recurrent aspiration pneumonia. As part of his treatment plan for pressure ulcers, R.M. needed to be repositioned regularly. R.M.'s care plan, completed by Chappy's upon his admission in 2017, noted that he required full medication management, two-person assistance with transfers, incontinence and catheter care, and total assistance with routine daily living activities. Towards the end of his time at Chappy's, as covered in the charging period here, R.M. was unable to speak more than a few words.

R.M. had medication and treatment orders issued by his attending physician in January 2018. The orders noted that R.M. needed hourly checks for his care, wound care on his right leg at least two times per day, and repositioning at least every two hours. The orders further said that R.M. was to be fed a modified diet including pureed meals that needed to be thickened to a honey-like consistency. These orders were modified throughout R.M.'s treatment at Chappy's, as described below.

1. R.M.'s Treatment During And Removal From Hospice Care.

On June 21, 2018, R.M. was placed on hospice care with a terminal diagnosis of recurrent aspiration pneumonia. After three months of hospice care from Grand Itasca Hospice Care (Grand Itasca), R.M. was discharged on September 24, 2018 because his aspiration pneumonia was no longer a terminal condition.

Nursing notes from the hospice nurses who visited Chappy's to provide care to R.M. show a worsening of a coccyx wound during the course of his hospice treatment. What started as a 3 cm x 5 cm coccyx wound on June 21, 2018 progressed to a 7.5 x 3.5 x. 2.5 wound with a "moderate" odor at a Stage IV thickness on September 18, 2018, according to health records. Upon discharge from hospice on September 24, 2018, however, R.M. did not have a UTI or sepsis. His catheter was also noted as being clean.

While hospice care nurses monitored R.M.'s wound and provided guidance to Chappy's staff on how to care for R.M.'s wound, Chappy's staff was responsible for day-to-day care of R.M.'s wound. R.M.'s hospice team regularly instructed Chappy's staff, including OLSON, that R.M. had to be kept off his bottom and repositioned every two hours to ensure his coccyx wound would heal. Former's Chappy's employees, including HHAs Amundson, Bailey, Marie Skelly, Ariana Elj, Sabrina Oswald, and S.E. reported that R.M. was not regularly repositioned. Oswald stated that R.M. was left in soiled undergarments and ignored. Bailey and S.E. recalled instances in which Chappy's staff were sleeping during night shifts instead of repositioning R.M. as required. Bailey recalled starting her shift and it was obvious R.M. had not been repositioned or had his diaper changed. Bailey stated that she told OLSON and MONIKA about issues with R.M.'s bottom, and both responded that it was an issue for hospice to deal with. Consistent with her statement, I found photographs of R.M.'s wound progression from Bailey on MONIKA's phone. MONIKA then then sent the photographs to OLSON. I found these photos, along with additional photos, that were dated as from September 2018, showing R.M.'s wound progression on a computer seized from OLSON's residence.

R.M.'s wound care was supposed to be provided by a nurse, yet, CNA April Fritze, stated she provided wound care to R.M. at Chappy's. R.M. suffered from other pressure sores prior to the one that contributed to his death. According to Fritze, when she brought R.M.'s worsening wounds to OLSON's attention, nothing was done. Fritze said that R.M. was frequently left in the same diaper for 12 hours at a time. Fritze said that she would initial R.M.'s diaper when she left, come back for her next shift, and R.M. would still be wearing the initialed diaper. Fritze stated that Chappy's workers left R.M. in a recliner all day and he would end up soaked in urine and waste from his mid-back to his knees. Fritze also stated that Chappy's workers consistently fed R.M. pureed cereal and milk, which was not consistent with his doctor's orders. R.M. would

gag and aspirate from this meal, and workers would simply pat him on the back and catch his vomit.

Fritze resigned from Chappy's in May of 2018. Shortly after she resigned, R.M. was placed on hospice care for his aspiration pneumonia. Chappy's documentation of R.M.'s food and medications listed his food consistency as being a "nectar" consistency, while the hospice orders directed he be provided food with a "pudding-like" consistency.

Former Chappy's resident D.K, who previously worked as a health aide, told MFCU investigators that Chappy's workers, including SALOMONSON, were frequently on their phones and not paying attention to R.M. while he ate. D.K. said that when R.M. was coughing and choking, the most Chappy's staff would do for R.M. was slap him on the back. Pagan and R.M.'s hospice care nurses all stated that this was improper treatment.

On multiple occasions, Chappy's denied hospice staff access to R.M.'s coccyx wound. After one of these occasions, RN Julie Heinrich, who oversaw R.M.'s hospice care, observed that R.M.'s wound had been dressed incorrectly by Chappy's.

Heinrich told the MFCU that OLSON was undertaking medical work far outside the scope of her LPN credentials. For example, Heinrich described OLSON as choosing to, without any doctor's orders or approval, treat R.M.'s coccyx wound in a different manner than was prescribed in his hospice orders. Shaye Edwall, a former Chappy's HHA, told me that she overheard OLSON tell HHA MEAGHER, not to follow hospice care orders.

Heinrich said that catheters on patients like R.M. needed to be cleaned at least twice a day. Based on Heinrich's observations when treating R.M., Chappy's staff was not regularly cleaning his catheter.

Heinrich and Michael Pihlaja, another RN at Grand Itasca, both described Chappy's resistance to any education or instruction from their hospice providers and nurses as unusual in their experience. Heinrich said that Chappy's, including OLSON, was unusually resistant to any assistance with or guidance for R.M.'s care. For instance, because Chappy's denied access to R.M.'s wound, Heinrich could not properly evaluate the severity of the wound that eventually developed sepsis. Heinrich said had she seen the wound and it was getting worse, she would have informed a doctor who would have ordered a new type of treatment.

In notes obtained from Chappy's premises, Chappy's employees indicated they used inserts rather than change R.M.'s diaper because the county only provided inserts. Heinrich stated this was not appropriate medical practice due to R.M.'s coccyx wound.

Heinrich said the only "nurse" she ever dealt with at Chappy's was OLSON. When I reviewed skilled nursing form in R.M.'s client file, I noted that forms dated September 12, 2018, June 28, 2018, and March 12, 2018 contained Pagan's signature. I further noted a comprehensive nurse assessment dated June 10, 2018 had Pagan's signature. When I spoke with Pagan, she stated she did not sign any of these forms for R.M. or evaluate him on these dates. Pagan said she had never even seen a form like the comprehensive nurse assessment in R.M.'s file.

Heather Lien, an RN who admitted and discharged R.M. from hospice care and provided some services to R.M. at Chappy's, stated Chappy's HHAs stood over Lien while she treated R.M. Lien said that she believed R.M. was not being repositioned as needed because she did not see much progress between the time R.M. was placed on hospice and the time he was discharged. Lien said she asked to speak with Chappy's RN and none was on site. Lien said she never talked with Chappy's RN and only dealt with the LPN, who she identified as OLSON. Lien said that a doctor's orders cannot be accepted in a facility like Chappy's without having an RN sign off of the doctor's orders. OLSON is not an RN and could not sign off

on them herself.

Each time Lien went to Chappy's, R.M. had been placed in a recliner. Lien explained to R.M.'s caregivers, including OLSON, that while a recliner may be comfortable, R.M. needed to be repositioned regularly. Lien stated that constantly leaving R.M. in a recliner could have led to or exacerbated the wounds on R.M.'s coccyx and led to an infection such as sepsis.

Lien said that upon R.M.'s discharge from hospice, he did not have any wounds with signs of sepsis. Lien asked OLSON whether Chappy's had the supplies necessary to care for R.M.'s wounds. OLSON assured Lien that she had what she needed. Lien said she reported all of R.M.'s conditions to OLSON upon discharge and the treatments R.M. needed. Lien said that OLSON acknowledged understanding this with her. Lien said that improper treatment – such as adding stool to an untreated wound on R.M.'s coccyx – could absolutely lead to sepsis. Lien explained that catheters needed to be cleaned at least twice per day. Lien further said that Chappy's RN should have evaluated R.M. for sepsis signs; when R.M. contracted sepsis, Chappy's did not have an RN on staff. Lien further explained that Chappy's LPNs, OLSON and MONIKA, would have a duty to observe R.M.'s condition and report it to the RN. Lien stated it would not be appropriate for an LPN to make these health care decisions without consulting an RN.

SALOMONSON, R.M.'s primary HHA during Chappy's day shift, stated she repositioned R.M. every two hours. SALOMONSON statement was inconsistent with the statements of numerous other Chappy's workers and medical providers. SALOMONSON agreed that shortly before R.M.'s death, urine was not flowing into his catheter, which "was a problem." SALOMONSON said that she would not change a catheter because that was only to be done by LPNs and RNs and believed hospice was responsible for catheter changes.

ELLIS provided false and misleading information to MFCU investigators during the investigation into R.M.'s death. As just two examples, ELLIS stated that she personally observed Michelle Pagan received training on R.M.'s wound care from R.M.'s hospice nurses. By the time R.M. went into hospice, Pagan was no longer working at Chappy's. Hospice care nurses stated that when they went to Chappy's, the only "nurses" they dealt with were OLSON and MONIKA. ELLIS also falsely stated that Pagan changed R.M.'s catheter in the days before his death, even though Pagan had quit working at Chappy's at this point and was no longer providing any services to Chappy's residents.

While R.M. was on hospice care and after his discharge, he did not receive any care or visits from any RN, including Pagan. I showed Pagan documents in R.M.'s client file. Pagan identified skilled nurse notes for dates of September 12, 2018, June 28, 2018, and March 12, 2018 as documents that had her name signed to them but were not actually her signature. Pagan further identified a comprehensive nurse assessment dated June 10, 2018 as a form that had her name signed to it but was not her signature. In her interviews with MFCU investigators, Pagan confirmed she did not evaluate R.M. or provide him with any care after she resigned from Chappy's.

2. R.M.'s Death

Following R.M.'s discharge from hospice, from September 24, 2018 to October 3, 2018, Chappy's staff documented symptoms that included coughing and wheezing; mucus and pus from R.M.'s catheter; an elevated temperature; low blood pressure; vomiting; and "green discharge and other foul smelling drainage" during wound care. On September 29, 2018, OLSON emailed a photograph of R.M.'s coccyx wound to herself. The wound was pitch black and covered a significant portion of R.M.'s bottom. There was no documentation that a RN was notified of R.M.'s symptoms or the condition of his coccyx wound.

R.M. was not taken to Grand Itasca Wound Care until October 5, 2018, when he was evaluated by Dr. Lisa

Owens. Dr. Owens documented an unstageable pressure ulcer extending to R.M.'s rectum. Chappy's workers told Dr. Owens that they tried to change R.M.'s wound dressing twice per day, but that it was difficult to do so because he sat in a chair quite a bit. Dr. Owens stated that based on her observations, R.M. sat on his wound most of the day and proper treatment would have been for Chappy's to have repositioned R.M. every two hours.

On October 6, 2018, R.M. was taken to Grand Itasca Hospital, then airlifted to St. Mary's Intensive Care Unit (ICU) in Duluth due to respiratory distress. Hospital records indicated that R.M. arrived in septic shock, had "chunky urine" in his catheter bag, had bilateral groin burns consistent with urine and yeast, and at least a 25 cm x 25 cm open wound from his buttock to low back draining foul smelling liquid with the appearance of necrosis (death of cells in living tissue). R.M.'s white blood cell count was documented as being very high, and he had a dangerously low hemoglobin. The physician also documented the client's left elbow was bruised with a three cm round lesion consistent with a burn.

RN Nicole Lingle, who treated R.M. at St. Mary's in Duluth, stated that R.M. arrived at the hospital dirty and unkempt, with what appeared to be a cigarette burn on his arm, a filthy catheter, and a groin caked in yeast. Lingle described R.M.'s coccyx as the worst pressure sore she had ever seen. Lingle said the wound was completely black in color and its odor was so pungent that the entire nine-bedroom ICU smelled like his wound. Lingle estimated R.M.'s wound was an inch deep. Lingle said all nurses treating R.M. used masks and put Vick's Vapo-Rub under their nose to combat the smell. Lingle said that when nurses pressed on R.M.'s wound, they could feel bone. Lingle said that it would take weeks for R.M.'s wound to get as bad as it did and that a wound could only get this bad as a result of "utter, complete neglect." On a 1-10 scale with 10 being the worst, Lingle described R.M.'s coccyx wound as being a 10 and his UTI being an 8.

Lingle said she believed R.M. was septic from the coccyx wound, but noted that he also could have been uroseptic from his catheter not being cleaned. Lingle said that R.M. would have been in obvious pain from his medical conditions. Hospice nurse Heather Lien stated that when R.M. was discharged from hospice, his catheter was clean and he did not have any UTI issues.

Dr. Steven Hanovich, who also treated R.M. upon R.M.'s admission to St. Mary's Hospital in Duluth, described R.M.'s groin area as bright red, consistent with urine burns. Dr. Hanovich said that for urine to get chunky like R.M.'s was, the infection would typically be going on for "awhile," which he described as "more than a few days." Dr. Hanovich said that R.M.'s urine burns would likely only occur if R.M.'s catheter was not being cleaned regularly or if he was sitting in feces or another liquid, such as diarrhea, without being changed. Dr. Hanovich said that, in his opinion, R.M. had the appearance of an individual who was not being regularly cleaned. When asked to rate how bad R.M.'s urine was on a scale of 1-10, with 10 being the worst, Dr. Hanovich said it was a 10. Dr. Hanovich said that an infection like R.M. had is a "never event" that would need to be reported to the State if R.M.'s infection occurred while R.M. was in a hospital.

Dr. Hanovich said his first thought when he saw R.M.'s coccyx wound was "how does [a wound] get to this point" and that none of the ICU nurses had ever seen a wound like R.M.'s. Dr. Hanovich said the wound extended from R.M.'s bottom to the small of his back, encompassed his anus and the cheeks on his bottom, and was roughly 10-12 inches long. Dr. Hanovich further described the wound as "unstageable," meaning he could not see how deep the wound was, but that if he had to classify it, the wound would have been a Stage IV as the most serious wound. Dr. Hanovich said the only time in his career he had seen a similar wound to R.M.'s was when a man who could not ambulate was left in a recliner, continuously, from Memorial Day to the Fourth of July.

R.M. died at St. Mary's on October 6, 2018. Dr. Hanovich said that R.M. ultimately died of septic shock from multiple organ failure. Dr. Hanovich said that R.M., in his opinion, had an awful life that he would not have chosen for one of his loved ones, and that he would have had a much more appropriate care plan in place for R.M.

Dr. Anne Bracey of the Midwest Medical Examiner's office conducted an autopsy on R.M. She noted on the autopsy that R.M.'s cause of death was dysphagia with a urinary tract infection being a contributing cause. Dr. Bracey told me she did not evaluate R.M. for sepsis because by the time she received the body, it was too late to conduct such an evaluation.

Chappy's received around $200 a day to care for R.M. During the time R.M. was on hospice and the time period between when he was discharged from hospice and when he passed away, Chappy's did not have an RN on staff or visiting Chappy's. Chappy's waited almost two weeks to seek medical treatment for R.M. after documenting a large, black wound with foul smelling drainage on his coccyx; coughing and wheezing; elevated temperature and low blood pressure; and vomiting. At that time, medical providers described his condition as one of the worst they had ever seen, consistent with "complete and utter neglect." R.M. died the next day.

B. Neglect of S.N.

S.N. suffered from a number of medical issues, including behavioral disturbance, delusional thoughts, hypertension, incontinence, and possible multi-infarct dementia. Despite medical records stating S.N. should not be placed in a location where vulnerable women lived, due to his sexual preoccupation, S.N. began living at Chappy's on June 16, 2018. He passed away on November 6, 2018. During his residence, Chappy's received $451.62 per day for his care.

In an interview with Aitkin County investigators, OLSON acknowledged that S.N. was supposed to receive 1:1 care from Chappy's HHAs. During the entire time S.N. resided at Chappy's, he was not seen by an RN. Pagan told me that she did not conduct an initial nursing assessment of S.N. as required by Minnesota law, did not conduct any skilled nurse visits with S.N. and was not contacted by Chappy's about S.N.'s medical issues. Chappy's, however, signed numerous documents, including S.N.'s intake assessments and skilled nurse notes, with Pagan's signature. Chappy's also had incident reports documenting S.N.'s medical issues that stated Pagan or "RN" were called. Pagan reviewed these documents and confirmed she did not sign them.

In September 2018, S.N.'s condition deteriorated. On September 10, HHA Skelly told OLSON that S.N. was not acting right, could not talk, was leaning to his left in his wheelchair, and looked like he had a stroke. Both Skelly and ELLIS, another home health aide, said S.N.'s blood pressure was very high the next day. Skelly eventually transported S.N. to the Deer River hospital in her personal vehicle on September 11, 2018. S.N. was then airlifted to a hospital in Duluth where he was diagnosed with an intracranial hemorrhage.

OLSON stated that after Skelly brought S.N.'s condition to her attention, OLSON took S.N.'s vitals, called "the nurse" (Pagan), spoke with the nurse, and then declined to seek medical attention. Skelly said that OLSON did not take S.N.'s vitals. Pagan's cell phone records show that Pagan did not receive any phone calls from OLSON on this date. Additionally, Pagan did not receive any text messages on this date, and text messages between OLSON and Pagan days later bore no mention of S.N. When I interviewed Pagan, she told me that nobody spoke to her about this incident, which occurred 4 months after Pagan's resignation. Finally, when I reviewed digital evidence from SWANSON's phone, I located a message from OLSON to SWANSON on September 10 indicating that she received 48 calls from work and just hung up.

According to cell phone records of ELLIS, she sent OLSON a text message on Sept. 11, 2018 at 6:58 A.M. reporting that S.N.'s blood pressure was high and that he was having trouble speaking. ANDERSON was copied on the text. On Sept. 12, 2018, ELLIS sent OLSON another text stating that OLSON was told a month before that S.N.'s blood pressure was too high and that ELLIS was upset nothing was done. ELLIS

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indicated she also told ANDERSON. OLSON responded to ELLIS by stating, in part, that OLSON should have sent S.N. to the hospital the day prior to September 11, 2018.

On December 5, 2018, shortly after an MDH onsite, OLSON asked ELLIS, in a text message, if ELLIS was present when S.N. had a brain bleed in September and who directed S.N. to get in the car. ELLIS responded by stating that Skelly took it upon herself to bring S.N. to the hospital, S.N. did not want an ambulance, and S.N. could not dress himself. OLSON responded by saying “We can’t say that Suzee hurry up so we can figure this out.”

C. Neglect of K.P.

K.P. became a resident at Chappy’s in October 2018. An assessment of K.P., conducted in October 2018, noted that K.P. needed assistance with nearly all activities of daily living, including transferring, range of motion, medication management, finances, and telephone use. The intake assessment also noted cognitive functional limitations including bipolar disorder, PTSD, failure to thrive, and general cognitive impairment. K.P. was further noted to have diminished judgment, both short and term memory loss, and neurological issues such as disorientation, dizziness, and unsteady gate. The assessment described safety measures for K.P.’s care including assisting with ambulation and transfers, keeping a telephone within reach, and having a nurse call button available.

K.P.s’ assessment and abuse prevention plan was dated October 23, 2018 and contained signatures that appeared to be Pagan’s. When I showed these documents to Pagan, she stated she did not sign the documents or conduct a nursing assessment. Pagan said she never met K.P.

According to witness statements, and a surveillance video I reviewed, on December 6, 2018, K.P. slipped and fell on an icy deck outside Chappy’s in the early morning hours. When she fell, she was wearing shorts and a light sweatshirt despite the temperature being close to zero degrees. After she fell, K.P. was picked up and carried inside by N.I., a HHA at Chappy’s who was not submitted for a background study and would not have passed due to prior felony convictions, including convictions that resulted in an executed prison sentence in June of 2018 due to multiple probation violations. After her fall, K.P. was not taken to a doctor until hours later, after MDH officials and Aitkin County social workers came to Chappy’s as part of an investigation. At that time, a social worker called an ambulance and K.P. was taken to the hospital, where she was diagnosed with a broken hip.

According to an incident report from Chappy’s, HHA Stephanie Andrews, called the manager (ANDERSON) and owner (OLSON) and reported K.P.’s injury. During execution of the same warrant, I located a statement purporting to be written by Andrews that differed from the incident report written; for example, in the statement, Andrews describes personally taking K.P.’s vitals, where in the progress note she states other people took K.P.’s vitals.

Prior to execution of the search warrant, Chappy’s attorney provided Aitkin County Sheriff’s Office with copies of other incident reports regarding K.P.’s fall stating that Pagan was notified of K.P.’s fall and kept up to date throughout the day. Based on my review of Pagan’s phone records and text messages, there is no record of Chappy’s staff members calling, texting, or otherwise notifying Pagan of K.P.’s fall and subsequent injuries. Pagan confirmed to me, in an interview, that she did not evaluate K.P. on December 6, 2018, nor did she know of K.P’s injuries.

During execution of a search warrant, I located a notebook at OLSON’s residence that contained a section titled “debunk [K.P.].” The notebook states that 911 was not called because K.P. was her own guardian and K.P. declined medical attention after consultation by nursing staff. As noted above, Chappy’s own intake assessment noted that [K.P.] had cognitive impairments including diminished judgment and both short and

long term memory loss. Chappy's own abuse plan also noted that K.P. could not recognize hazardous situations, could not recognize or protect against potential health or safety risks, could not protect herself from situations involving abuse and neglect, and did not report incidents involving abuse or neglect.

The notes seized in the search warrant also stated that 911 was not called because there K.P. did not have any protruding bones, bleeding, or bruising. The notebook further stated that "Lisa Anderson 'manager' was on the phone w/ medivan scheduling transport for (K.P.) when the holocaust reincarnated." ANDERSON also stated that she called Medi-Van for K.P. I spoke with Lynn Dorff, the supervisor at Medi-Van, regarding transportation requests by Chappy's. Dorff stated there was no call made for medical transportation for K.P. on December 6 or December 7, 2018.

D. Neglect of E.W.

E.W. is paralyzed from the neck down and relies on caregivers for all activities of daily living. E.W. did not have any documented cognitive impairments and did not have a guardian or conservator. E.W. said he worked as an LPN prior to his injuries.

E.W. was admitted to Chappy's in July 2016. He resided at Chappy's until its closure. His admit book stated that he needed administration and storage of medications, including insulin. E.W. also required a daily sponge bath, catheter care, stoma care, transportation to medical appointments, and skilled nurse visits. Pagan signed a vulnerability assessment indicating E.W. was a vulnerability risk.

Chappy's received over $500 a day to care for E.W. E.W. described OLSON as recruiting him to come live at Chappy's with promises of certain living facilities, including a private bathroom. E.W. said these facilities were not provided. E.W. stated that Chappy's staff had zero nursing or personal care knowledge or training and did not know how to handle his conditions. E.W. said it made him most concerned for other residents who did not have the ability to advocate for their own care. E.W. said he was lucky to have staff visit him more than twice per day.

E.W. described Chappy's routinely neglecting his care and the care of other residents. For example, E.W. said that he needed to have regular catheter changes and, due to his conditions, had regularly scheduled doctors' appointments. E.W. stated that he did not have regular catheter changes and, as a result, developed multiple urinary tract infections. E.W. further stated that he missed at least four medical appointments due to Chappy's staff not bringing him.

E.W. stated that his medications regularly ran out without being filled by Chappy's staff. E.W. explained that he was prescribed Lyrica, which is used to treat nerve and muscle pain and can be used to treat seizures. E.W. was supposed to receive Lyrica every 8 hours. E.W. said that on one occasion, he ran out of Lyrica for four days, which led to excruciating pain. E.W. stated ANDERSON was responsible for refilling E.W.'s medications, including Lyrica. E.W. said that Chappy's did not fill other prescriptions of his regularly, including diabetic supplies.

E.W. further said that he rarely saw Pagan at Chappy's. E.W. said he was supposed to see Pagan weekly, but that he did not see her nearly this often. E.W. said he would, sometimes, see Pagan for a couple weeks in a row, then would not see Pagan for months. E.W. said that the nursing services Pagan provided were largely limited to clipping his toenails. E.W. said that when Pagan did show up to provide services at the facility, she would typically arrive at 5 P.M. on a Friday and leave by 7 P.M., despite having over 20 residents to evaluate. E.W. said that Pagan did not monitor his catheter.

E.W. said that when he complained about his care, Chappy's employees, including OLSON, responded with insults and profanity. E.W. observed OLSON instructing her staff to rewrite progress notes. E.W. said

that Chappy's staff talked about how they had felonies, and that OLSON paid those with felonies "under the table" with cash.

During execution of a search warrant at Chappy's, MFCU investigator seized white boards detailing Chappy's response to E.W.'s allegations. The white board appeared to be a script for Chappy's employees to follow when answering questions from MDH investigators; Chappy's employees who denied E.W. was neglected gave answers that were substantially similar to what was outlined on the white board. Before the MFCU seized these white boards, HHA Sabrina Oswald told MDH that OLSON held meetings with Chappy's workers go over a script for MDH.

E. Neglect of E.L.

E.L. was a resident who suffered from numerous mental health issues, including intense anxiety and suicidal ideations. A mental health evaluation conducted in March 2019 noted E.L. was highly vulnerable to sexual, physical, financial, and mental maltreatment. E.L.'s health screening noted she needed, among other services, medication management and daily blood pressures at bed time. The notes further indicated E.L. needed significant structure and support to thrive.

E.L. resided at Chappy's unlicensed top house. She received Adult Rehabilitative Mental Health Services (ARMHS) through Northland Counseling. Jennifer Klev, E.L.'s ARMHS worker, regularly visited E.L. at Chappy's. On multiple occasions, Klev observed conditions in E.L.'s room, including holes in the closet that led to the exterior of the home, a broken window and door, visible water damage, and rodent nests and feces, that led to Klev filing a report with the Minnesota Adult Abuse Reporting Center (MAARC).

Klev also stated that when E.L. told OLSON she planned to move out of Chappy's in June 2018, OLSON feigned tears and responded: "how could you do this to me, I'm your friend, I don't want you to leave." Klev wrote, in her MAARC report that she submitted after these incidents, that E.L.'s mental health has been in constant chaos and that E.L. is not able to identify when OLSON is acting inappropriate. According to the MAARC report, E.L. had asked Klev not to report these incidents.

Aitkin County Undersheriff Heidi Lenk, Aitkin County Sheriff's Deputy Sheryl Cook, and I spoke with E.L. E.L. said that prior to becoming disabled, she worked as a CNA. E.L. confirmed that she began living at the top house in March 2018. E.L. described difficulty getting her medications when she was supposed to, and occasionally missing doses. E.L. said that at one point, she went a week without Clozapine, an antipsychotic medication.

E.L. further said that ANDERSON completed her care plan at Chappy's, despite the care plan bearing Pagan's signature. ANDERSON is not an RN.

Chappy's received $736.56 every day that E.L. resided at Chappy's. E.L. told us that she was "200% better" after she left Chappy's.

F. Neglect of E.T.

E.T. is a Chappy's resident who moved into the facility in December 2017. Chappy's received $233.41 per day for E.T.'s care. E.T. suffers from a number of mental health issues, including psychosis and paranoid schizophrenia. E.T. also has a history of assaultive behavior, including a felony assault charge for a stabbing incident in South Dakota in 2015. E.T. takes a number of medications for his mental and physical conditions. Some of these medications, such as disulfiram, which was prescribed to support treatment of E.T.'s alcoholism, were not to be taken with any alcohol. Other of E.T.'s medications directed that alcohol was to be limited when taking them.

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Witness interviews described E.T. as frequently intoxicated at Chappy's. According to Fritze, who worked at Chappy's from late 2017 until May 2018, OLSON allowed E.T. to drink at Chappy's and even bought him alcohol on occasion. HHA Ashley Poirier also said that OLSON instructed Chappy's workers buy alcohol for E.T. HHA Valerie Shepard witnessed E.T. drinking at Chappy's and said OLSON provided alcohol to him.

G. Assault of P.A.

P.A. is a quadriplegic who resided at Chappy's in the summer and fall of 2018. On October 24, 2018, Hill City Police Chief Joshua Kimball spoke with P.A., who stated that MATTSON-OLSON struck P.A. in the stomach, chest, and face after P.A. accidentally ran over MATTSON-OLSON's foot with her wheelchair. While SWANSON stood near her, P.A. then declined to give further detail. Later in the day, Kimball again spoke with P.A. P.A. then explained that MATTSON-OLSON struck P.A. in the stomach with a closed fist, in the face with an open hand, and in the chest with the back of her hand.

Kimball spoke with MATTSON-OLSON, who acknowledged that P.A. ran over her foot. MATTSON-OLSON denied hitting P.A.

I reviewed evidence obtained from an email search warrant executed on OLSON's email account. I found an email send by MATTSON-OLSON to OLSON in late December 2018. The email contained a recorded phone call between P.A. and SWANSON. In the phone call, SWANSON is asking P.A. about allegations made against Chappy's that relate to her. P.A. reiterated to SWANSON that MATTSON-OLSON hit P.A. P.A. then told SWANSON that she was "not pressing charges" and that if the State asked, she would say that she was too drunk to remember anything that happened. SWANSON concluded the phone call by telling P.A. not to speak with the State anymore.

H. Neglect of M.B.

M.B. moved into Chappy's on May 9, 2018. Chappy's received $398.03 a day for his care. M.B. resided at Chappy's until he passed away in August 2018. M.B. suffered from numerous medical conditions, including alcoholism.

Megan Parrington, M.B.'s case manager, said that OLSON told her M.B. was allowed to have one alcoholic drink in the morning and one in the evening, despite a care plan saying that M.B. was not permitted to drink. HHA Palkii said she worked directly with M.B. and that M.B. would drink straight from a bottle of Jack Daniel's. Palkki brought this to OLSON's attention before she quit.

When I executed a search warrant at Chappy's premises on March 28, 2018, I seized one client file with M.B.'s name on it. The file did not have an intake assessment, abuse prevention plan, risk assessment, or other similar assessments. I did not find any nursing notes or logs detailing activities of daily living for M.B. I also did not find any logs of M.B.'s vitals or any medication logs for M.B.

I. Neglect of A.L., R.A., M.B., D.M., J.M., L.S., and C.S.

Minnesota law requires that when a resident starts receiving comprehensive home care services, an individualized assessment of a resident must be conducted in person by an RN. Residents A.L., R.A., M.B., D.M., J.M., L.S., and C.S. all moved into Chappy's after Pagan resigned. Pagan stated she did not complete assessments for these patients. Chappy's did not employ any other RN.

Minnesota law also requires client monitoring and reassessment to be conducted within 14 days of

initiation of services, and ongoing client monitoring must be re-conducted on an ongoing basis, at least every 90 days but I did not find any documentary evidence showing that any of these residents were evaluated by an RN during their time residing at Chappy's.

After MDH began investigating Chappy's, OLSON messaged MONIKA on December 7, 2018 and asked her to create service plans for Chappy's clients. MONIKA responded approximately 8 hours later with screenshots of service plans for 31 Chappy's residents, including A.L., D.M., J.M., L.S., and C.S. Shauna Kasper, the guardian for C.S., noted that her signature on C.S.'s treatment plan – which was required by Minnesota law to be signed by the client or the client's representative – was not hers and that the medical conditions listed on Chappy's records were not accurate. Pagan's signature appeared throughout these client files despite her not working at Chappy's or conducting assessments, intake plans, or any other client evaluations after she stopped working at Chappy's in early May 2018. Pagan said she did not sign these documents.

Chappy's received, per day, the following amounts for each individual's care:

M.B.: $434.21.

A.L.: $199.88.

D.M.: $245.69.

J.M.: $328.75.

L.S.: $288.09.

C.S.: $150.32.

J. Lack of Staff Training To Care For All Chappy's Residents.

Minnesota law requires HHAs who provide direct contact services in facilities licensed by MDH to receive certain training. Statutorily required examples includes successfully completing a written or oral test on the tasks they will be expected to perform, such as reporting changes in client condition to supervisors, fall prevention, medication reminders, basic nutrition and food preparation, procedures to use in emergency situations, and health technology. Comprehensive home care providers, like Chappy's, must further train personnel in additional areas like administering medications, safe transferring and ambulation, recognizing developmental and cognitive needs of clients, and basic changes in body functioning.

Pagan, Chappy's only RN, told me that she trained less than half of the approximately 70 HHAs affiliated with Chappy's when its license was suspended in December 2018. As discussed above, Pagan told OLSON that Pagan did not have the expertise to oversee a facility filled with residents with significant mental health needs. Pagan said she also told OLSON that HHAs needed specialized training to deal with these recipients, such as training on psychotropic use and mental health disorders.

There is no record Chappy's ever brought in an RN to train employees in how to provide services to clients with significant mental health issues. Minnesota law specifically provides that a home care provider, like Chappy's, may not accept a client unless it has staff qualified to provide the services and that the services are within the provider's scope of practice.

Interviews with former Chappy's employees, including Amundson, Bailey, Palkii, Ryanne Jessme, Skelly, Valerie Shepard, Ariana Elj, and Amber Fritze demonstrated that Chappy's did not train numerous HHAs and that when it did, the training provided by Chappy's was inadequate. Former Chappy's workers also

noted other training discrepancies, such as allowing workers to start prior to receiving any training. Other employees, including Bailey and Shepard, said they received no training from a nurse on how to care for Chappy's clients with mental health issues. Some former workers, including Amundson and Ariana Elj, who was 16 when she began working at Chappy's, said they received no training at all.

IV. Falsification of Documents, Interference With State Investigations, and Coercion of Witnesses.

Minnesota law requires a facility like Chappy's to document health care services provided to its residents for five years after death or discharge from the facility. This documentation includes care plans, assessments, significant changes in the client's status and reports to appropriate professionals, and notes on services provided. Minnesota law for licensed home care providers prohibits staff and owners from knowingly making false statements of material fact in reports documenting services provided or destroying or making unavailable records related to services provided or licensing issues.

Former Chappy's employees described efforts by OLSON, MONIKA, ANDERSON, SWANSON, MATTSON-OLSON, DAVIS, ELLIS, HINES, MEAGHER, and other Chappy's employees to falsify documents in response to requests from the MDH and other agencies. Witnesses also described efforts to interfere with MHD's investigation. Digital evidence confirmed these activities occurred. Most frequently, the documents Chappy's falsified appeared to have been done to cover up Chappy's failure to provide RN oversight and appropriate medical care of residents, use of HHAs who had not passed a background study (discussed on more detail in Section IV), and incidents that led to resident injuries.

For instance, R.M.'s client file included records of care purportedly provided by Bailey after she stopped working at Chappy's and records containing MEAGHER's signature, when in fact, the narrative portion of daily notes indicate that N.W., who did not pass a background study and would not have due to a prior conviction for solicitation of a minor, actually provided the services. MONIKA's signatures and initials were also written over the name of another provider of R.M. For example, MONIKA's initials and signature are written over those of another provider as performing R.M.'s ADLs on July 26, 2018. The narrative section of R.M.'s July 26, 2018 health records does not have MONIKA's signature. Additionally, for August 5, 2018 – on the same ADL sheet containing MONIKA's overwritten initials and signature – Kristin Weed's name and initials appear to be substituted for Nick Weed's name and initials.

R.M.'s medication administration records include records for September 31 (there are only 30 days in September), and the initials of Bailey, who was not working at Chappy's at the time. In an interview, DAVIS admitted to "re-writing" R.M.'s client file after his death.

Review of HINES's text messages showed her texting with MEAGHER, another Chappy's HHA, about "doing client books" in October 2018. HINES and MEAGHER discussed finishing client books for R.M., C.S., and S.L.T. and then spoke about which ones still needed to be completed. R.M. passed away the next day.

HHA Skelly described OLSON as walking through Chappy's and telling people that client "books" needed to be completed or Chappy's would be shut down. Cynthia Peterson told MDH investigators that OLSON told Peterson and Donna Aubrey, another Chappy's home health aide, to re-write client "books." Jessme told MDH investigators that OLSON told her and other Chappy's staff to just complete client "books" after a shift regardless of whether they actually provided services. S.E. told me that MATTSON-OLSON and MEAGHER falsified documents. Ashley Poirier, a former Chappy's HHA for five years, said that she personally falsified documents and that on one occasion, OLSON, MONIKA, and Lacey Olson, (MONIKA's sister), brought client books into the bathroom during an MDH onsite and falsified documents because they knew "the State" would not come into the bathroom. Bailey, another former Chappy's HHA, told me she

personally falsified documents at management's request. HHA Valerie Shepard stated she witnessed OLSON, MONIKA, ELLIS, and DAVIS re-write files after MDH's onsite; ELLIS's signature is frequently written over that of S.E., a Chappy's HHA with the same initials who was not submitted for a background study and would not have passed. Amundson stated Chappy's employees constantly re-wrote nursing notes and other medical records, and OLSON told employees, including Amundson that they would not be paid unless they re-wrote documents. Amundson observed T.H, a resident with significant mental health issues that made her susceptible to manipulation and coercion, falsify documents at OLSON's request. Resident E.L. reported that after Chappy's license was suspended, OLSON, MONIKA, ANDERSON, and SWANSON took client files into Chappy's basement and spent a month altering and creating new documents.

Review of MONIKA's text messages with OLSON showed them discussing the completion of client files well after Chappy's was shut down. On January 22, 2019, when MDH was investigating maltreatment allegations against T.F., OLSON and MONIKA talked about how T.F.'s medications were all wrong upon T.F.'s discharge from the hospital. MONIKA then responded by saying "make a separate med sheet for them? And say you forgot to send it." MONIKA and OLSON continued to exchange messages while MONIKA indicated she was looking up T.F.'s medications in Thrifty White's database, where she was employed. On January 29, 2019, OLSON and MONIKA discussed filling out T.F.'s "home visit sheets."

During a search warrant at Chappy's, I found a checklist of client "books" that had been completed for clients who resided at Chappy's in 2017 and 2018, the timeframe of MDH's investigation. Notably, despite Minnesota law requiring providers to keep documentation of services for 5 years, Chappy's had minimal client files, either on site or in OLSON's home or in a storage locker I searched pursuant to a warrant, for residents who lived at Chappy's prior to 2017.

Evidence seized from Chappy's included pre-signed daily care logs and nursing notes for services that could not have been provided because the recipient was hospitalized at the time. For instance, J.A. was not at Chappy's from June 4, 2018 through June 6, 2018, as shown by inpatient hospital records. Chappy's also had notes documenting that indicated J.A. was offsite from June 4, 2018 through June 6, 2018. Yet Chappy's nursing notes indicated that J.A. received services from Denita Boden from June 4, 2018 through June 6, 2018.

Pagan identified numerous skilled nursing notes and other health records for recipients including, but not limited to, R.M., S.N., K.P., C.S., and C.L., for services she did not provide and did not sign off on. In some cases, Pagan's signature appeared on documents dated after she resigned from Chappy's.

Pagan said that after the MDH onsite, OLSON gathered Chappy's employees together and directed them to provide misleading information about R.M.'s death to the State. OLSON directed workers to deny any problems, tell investigators that R.M. was on hospice, and say that R.M.'s injuries were the hospice care team's fault because Chappy's never received wound care orders. OLSON directed employees to say that R.M. had trouble breathing after a wound care appointment, and that Chappy's called 911 right away. OLSON also told employees that R.M. died from a blood clot and not sepsis.

Former Chappy's employees Pagan and Skelly told MFCU investigators that whenever a Chappy's resident went to the hospital, OLSON wanted a Chappy's worker with them. Resident D.K. told MFCU investigators that ANDERSON accompanied her to psychiatry appointments even after D.K. stated that she did not want ANDERSON present.

Evidence seized from Chappy's included three white boards with E.W.'s name on top and a written description and response to E.W.'s allegations made to MDH. The writing on the white boards was similar to the "defense" that Chappy's gave to E.W.'s allegations made to MDH, and appeared to be a script for Chappy's employees to follow when responding to MDH questions.

SALOMONSON falsely reported to the MFCU that Pagan visited Chappy's twice per week and saw R.M. in the weeks before his death. SALOMONSON repeated some other details of OLSON's cover story, too, such as saying that hospice car was responsible for R.M.'s day-to-day wound care. ELLIS repeated many details of the same story, including falsely reporting that Pagan cared for R.M. before his death. At the time these statements were made, the MFCU was investigating second degree manslaughter charges relating to R.M.'s death.

On December 6, 2018, MDH and county social workers began relocating Chappy's residents to other facilities. On December 7, 2018, MONIKA and OLSON texted about a state law requiring facilities to provide residents' service plans upon relocation. Approximately 8 hours after receiving this text, MONIKA texted and emailed hundreds of images of OLSON. These images were of service plans for 31 Chappy's residents: K.P., E.Y., R.S., C.S., R.T., A.L., R.T., L.S., R.A., M.S., T.F., C.J., S.P., G.W., W.E. S.L-T., L.K., E.W., E.T., J.A., F.L., J.M., L.H., F.G., D.O., D.J., D.A., D.M., S.S., D.K., and J.J. The service plans had signatures from Pagan and, when appropriate, the resident's guardian. I showed multiple service plans pictured in these messages to Pagan, who confirmed that she did not sign these documents. Shauna Kasper, a guardian for some of the residents with these service plans, also confirmed she did not sign these documents and that some client medical conditions were not accurate. Barbara Stendel, a guardian for Chappy's resident C.C.L., also viewed assessments and care plans that purported to bear her signature. Stendel confirmed she did not sign these documents.

Pagan also told me that after MDH's investigation was underway, OLSON requested that Pagan sign blank employee discipline forms for OLSON to complete later. OLSON then completed these forms to make it appear as though employees were disciplined for instances of potential patient harm, and falsely indicated that Chappy's reported these incidents to Pagan. During a search warrant at Chappy's, I located forms that were pre-signed by Pagan.

I also located documents in Chappy's client files that were pre-signed. For instance, in the client file of S.S., I found timesheets that had initials of Chappy's providers stating that specific services were provided to S.S. However, there were no dates and times listed for the services provided on these timesheets. This indicated to me that Chappy's filled out daily service sheets for recipients in advance, or in response to an investigation, rather than documenting the services as they were provided, as required by law.

Chappy's also constructed incident reports for dates and times when a resident had an issue that could have resulted in harm. The incident reports consistently noted that either "Michelle" or "Nurse" or "RN" was called about a resident injury or inappropriate behavior. Pagan reviewed numerous incident reports for residents such as S.N., K.P. and R.M. for events that occurred after Pagan resigned. These incident reports indicated that Pagan was notified about the resident's incident. When Pagan reviewed them, she told me that she was not notified of what happened by any Chappy's employee. I reviewed Pagan's phone records and confirmed she did not have incoming calls (or text messages) from Chappy's employees that the employees claimed to have made in the incident reports.

Finally, Chappy's falsified documents in employee files to make it appear that workers who Chappy's did not submit for a background study until the Fall of 2018 began working at Chappy's only after their background study was submitted. For example, Chappy's had, on its premises when I executed a search warrant, an employee file for N.W. N.W. dated his application to Chappy's as October 10, 2017. He signed a W-4 form with the date November 29, 2017. He also had a caregiver orientation stated he received orientation from OLSON. The top of this document contained a "date" space that listed November 30, 2017. The bottom of the document contained a signature line for N.W., Pagan, and OLSON. Next to the signature block was a space to date the signature. Every signature's date listed the month of November. However, the date at the bottom of the document had "18" written over "17" for the year of the caregiver orientation. Other documents in N.W.'s employee file had dates that appeared to have "18" written over

"17," making it appear as if N.W. did not start working at Chappy's until November 2018. Notably, N.W. received wages of $31,414.00 from Chappy's throughout the calendar year of 2018. In N.W.'s employee file, his orientation document listed his start date as October 10, 2017. Chappy's did not run a backgrounds study on N.W. until November 2018, and N.W. has a prior conviction for electronic solicitation of a minor that would disqualify him from providing direct contact services to Medicaid recipients.

In an interview with MFCU investigator, N.W said that OLSON told him to tell any investigators that he did not start working at Chappy's until November 8, 2018. Phylisha Jarvi, another former Chappy's HHA, said that OLSON told her to lie about her start date so that it was consistent with the date of her background study.

V. The Olson Family's Dispensation Of Assets Following Notice Of The Investigation.

The Olson family undertook extensive efforts to dispose of assets following the commencement of MDH's investigation.

For example, the Olsons purchased 540 Park Avenue in Hill City, where Chappy's was located, in 2001. In February 2019, after an administrative law judge issued an order suspending Chappy's home care license, this property was transferred from Keith Olson to MONIKA. MONIKA then listed this property as the address for Mont Royal when she attempted to obtain a comprehensive home care license. Similarly, the 604 Summit Avenue property, purchased by Keith in 1998, was "sold" to MONIKA in February 2019 for $1.00. Land in Hill City with parcel numbers 52-1-043700 and 57-1-043600, located at approximately 200 Pine Street, was sold by Keith Olson to MONIKA for $1.00 in February 2019. The 600 Summit Avenue property (the top house), purchased by Keith and OLSON in July 2017, was "sold" to SWANSON on December 17, 2018 for $1.00.

Finally, on December 7, 2018 – the day after an MDH onsite investigation that resulted in a temporary immediate suspension of Chappy's license - American Bank of the North issued Keith Olson him two cashier's checks from Chappy's business account. Each cashier's check was for $869,351.00. One check, #10455, was made out to both Keith and OLSON. The bank separately issued Keith a cashier's check for $10,000.00 on the same day in cashier's checks from Chappy's business bank account.

VI. Conclusion.

Chappy's owner, management and employees participated in a long-running scheme to defraud the Medicaid program out of over $2 million. During the course of these activities, numerous Chappy's residents were subjected to neglect which in one case, caused a resident's death. Chappy's owner, management and employees went to substantial efforts to conceal this criminal conduct, and continued to provide services to residents after MDH suspended Chappy's license.

As discussed, OLSON directed, had knowledge of, and was responsible for criminal activities described in this complaint.

Filed in District Court
State of Minnesota
9/23/2019

SIGNATURES AND APPROVALS

Complainant requests that Defendant, subject to bail or conditions of release, be:
(1) arrested or that other lawful steps be taken to obtain Defendant's appearance in court; or
(2) detained, if already in custody, pending further proceedings; and that said Defendant otherwise be dealt with according to law.

Complainant declares under penalty of perjury that everything stated in this document is true and correct. Minn. Stat. § 358.116; Minn. R. Crim. P. 2.01, subds. 1, 2.

Complainant	Natalie J Seiler Investigator 445 Minnesota Street 900 Bremer Tower St. Paul, MN 55101	Electronically Signed: 09/20/2019 01:42 PM Ramsey County, nseiler

Being authorized to prosecute the offenses charged, I approve this complaint.

Prosecuting Attorney	Nicholas B. Wanka Assistant Attorney General 445 Minnesota Street 900 Bremer Tower St. Paul, MN 55101 (651) 297-1075	Electronically Signed: 09/20/2019 01:39 PM

Filed in District Court
State of Minnesota
9/23/2019

FINDING OF PROBABLE CAUSE

From the above sworn facts, and any supporting affidavits or supplemental sworn testimony, I, the Issuing Officer, have determined that probable cause exists to support, subject to bail or conditions of release where applicable, Defendant's arrest or other lawful steps be taken to obtain Defendant's appearance in court, or Defendant's detention, if already in custody, pending further proceedings. Defendant is therefore charged with the above-stated offense(s).

☐ SUMMONS

THEREFORE YOU, THE DEFENDANT, ARE SUMMONED to appear on ________ ___, _____ **at** _____ **AM/PM** before the above-named court at 209 2nd St NW, Aitkin, MN 56431 to answer this complaint.

IF YOU FAIL TO APPEAR in response to this SUMMONS, a WARRANT FOR YOUR ARREST shall be issued.

☒ WARRANT

To the Sheriff of the above-named county; or other person authorized to execute this warrant: I order, in the name of the State of Minnesota, that the Defendant be apprehended and arrested without delay and brought promptly before the court (if in session), and if not, before a Judge or Judicial Officer of such court without unnecessary delay, and in any event not later than 36 hours after the arrest or as soon as such Judge or Judicial Officer is available to be dealt with according to law.

☐ ***Execute in MN Only*** ☒ ***Execute Nationwide*** ☐ ***Execute in Border States***

☐ ORDER OF DETENTION

Since the Defendant is already in custody, I order, subject to bail or conditions of release, that the Defendant continue to be detained pending further proceedings.

Bail: $
Conditions of Release:

This complaint, duly subscribed and sworn to or signed under penalty of perjury, is issued by the undersigned Judicial Officer as of the following date: September 23, 2019.

Judicial Officer	David Hermerding Judge	Electronically Signed: 09/23/2019 01:01 PM

Sworn testimony has been given before the Judicial Officer by the following witnesses:

COUNTY OF AITKIN
STATE OF MINNESOTA

State of Minnesota
Plaintiff
vs.
Theresa Lee Olson
Defendant

LAW ENFORCEMENT OFFICER RETURN OF SERVICE
I hereby Certify and Return that I have served a copy of this Warrant upon the Defendant herein named.

Signature of Authorized Service Agent:

Filed in District Court
State of Minnesota
9/23/2019

DEFENDANT FACT SHEET

Name:	Theresa Lee Olson
DOB:	12/13/1975
Address:	604 Summit Avenue Hill City, MN 55748
Alias Names/DOB:	
SID:	
Height:	
Weight:	
Eye Color:	
Hair Color:	
Gender:	FEMALE
Race:	
Fingerprints Required per Statute:	Yes
Fingerprint match to Criminal History Record:	No
Driver's License #:	
Alcohol Concentration:	

Filed in District Court
State of Minnesota
9/23/2019

STATUTE AND OFFENSE GRID

Cnt Nbr	Statute Type	Offense Date(s)	Statute Nbrs and Descriptions	Offense Level	MOC	GOC	Controlling Agencies	Case Numbers
1	Charge	2/7/2017	609.903.1(1) Racketeering-Enterprise-Employed/Assoc/Participate	Felony	X1300	N	MN062015A	20190019
	Penalty	2/7/2017	609.904.1 Racketeering-Penalty	Felony	X1300	N	MN062015A	20190019
2	Charge	8/7/2018	609.52.2(a)(4) Theft-By Swindle	Felony	U1069	N	MN062015A	20190019
	Penalty	8/7/2018	609.52.3(1) Theft-Firearm or Property Value Over $35,000	Felony	U1069	N	MN062015A	20190019
3	Charge	2/7/2018	609.52.2(a)(4) Theft-By Swindle	Felony	U1069	N	MN062015A	20190019
	Penalty	2/7/2018	609.52.3(1) Theft-Firearm or Property Value Over $35,000	Felony	U1069	N	MN062015A	20190019
4	Charge	8/7/2017	609.52.2(a)(4) Theft-By Swindle	Felony	U1069	N	MN062015A	20190019
	Penalty	8/7/2017	609.52.3(1) Theft-Firearm or Property Value Over $35,000	Felony	U1069	N	MN062015A	20190019
5	Charge	2/7/2017	609.52.2(a)(4) Theft-By Swindle	Felony	U1062	N	MN062015A	20190019
	Penalty	2/7/2017	609.52.3(2) Theft-Value over $5,000 or Trade Secret, Explosive, Controlled Substance I or II	Felony	U1062	N	MN062015A	20190019
6	Charge	9/24/2018	609.205(1) Manslaughter - 2nd Degree - Culpable Negligence Creating Unreasonable Risk	Felony	H5002	N	MN062015A	20190019
7	Charge	8/15/2018	609.233.1a(1) Criminal Neglect - Knows/reason to know deprivation will result in substantial or great bodily harm	Felony	I1201	N	MN062015A	20190019
	Penalty	8/15/2018	609.233.3(1) Criminal Neglect - Felony Deprivation resulting in great bodily harm	Felony	I1201	N	MN062015A	20190019
8	Charge	8/15/2018	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
9	Charge	12/6/2018	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
10	Charge	9/10/2018	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
11	Charge	6/18/2018	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
12	Charge	7/16/2016	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
13	Charge	6/5/2018	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
14	Charge	5/9/2018	609.233.1		I2150	N	MN062015A	20190019

			Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Misdemeanor				
15	Charge	12/19/2017	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
16	Charge	6/22/2018	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
17	Charge	9/13/2018	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
18	Charge	5/9/2018	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
19	Charge	8/6/2018	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
20	Charge	4/16/2018	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
21	Charge	4/21/2018	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
22	Charge	10/1/2018	609.233.1 Criminal Neglect - Intentionally neglects or knowingly permits conditions to exist	Gross Misdemeanor	I2150	N	MN062015A	20190019
23	Charge	10/7/2018	609.495.3 Aiding an Offender - Accomplice After the Fact	Felony	E2B00	N	MN062015A	20190019
24	Charge	12/7/2018	609.496.1 Concealing Criminal Proceeds	Felony	X1280	N	MN062015A	20190019
	Penalty	12/7/2018	609.496.2 Concealing Criminal Proceeds-Penatly	Felony	X1280	N	MN062015A	20190019
25	Charge	12/7/2018	144A.471.4 Home care provider - Manage, operate or control home care provider without appropriate license	Misdemeanor		N	MN062015A	20190019