Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53188282M
Compliance #: H53183340C

Date Concluded: April 10, 2025

Name, Address, and County of Licensee Investigated:
Good Sam International Falls
2201 Keenan Drive
International Falls, Minnesota 56649
Koochiching County

Facility Type: Nursing Home

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) financially exploited the resident when the AP took the resident's Adderall (controlled stimulant medication).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. There was a preponderance of evidence the AP took the resident's Adderall pill when she went to a unit she was unassigned, spending time near the medication cart as another nurse passed medications. The AP had a history of frequently requesting to pass the resident's Adderall medication. Video footage showed the AP, in the narcotic medication box on a cart she was unassigned to that held the resident's Adderall.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, facility internal investigation, facility

incident report, personnel files, staff schedules, law enforcement report, and related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included narcolepsy (a condition that makes people very sleepy and fall asleep suddenly). The resident's care plan included assistance with medication administration. The resident's assessment indicated the resident had occasional complaints of daytime sleepiness.

The resident's record included an order for Adderall 20 milligrams (mg) one tablet by mouth two times a day, and one tablet by mouth one time a day for narcolepsy. The resident's medication administration record (MAR) indicated the resident received Adderall in the morning, at noon, and in the evening each day.

A facility incident report indicated nurse 1 notified nurse 2 of one of the resident's Adderall pills missing from the medication package. Staff checked the medication cart, garbage attached to the cart, and surrounding floor. They were unable to locate the missing Adderall pill.

An internal investigation indicated nurse 1 was going to administer the resident's evening Adderall and noticed the narcotic count was correct in the book but when she compared it with the medication card, it was missing one pill. The AP had been on the unit for about one and a half hours, standing around the medication cart as nurse 1 began to pass medication. After nurse 1 noticed the missing medication, the facility interviewed nurse 1 who reported the AP regularly requested to administer the resident's Adderall medication. The AP had been assigned to another unit during the time of the incident, however she displayed suspicious behavior around the medication cart and was interviewed. The AP denied taking the Adderall. When asked why she was in the narcotic drawer, she said she did not know why. When asked if she had any reason to access the medication cart, the AP stated she had been looking for a morphine syringe for her unit and was then asked to give another resident a narcotic medication. During the investigation, nurse 3 was interviewed who stated she had not been in her office when nurse 1 left the medication cart keys in there. She had been in a meeting and did not find anything out about the incident several days later, as she left early the day of the incident. A staff member on the AP's unit reported she called the AP on the radio several times, but the AP did not respond. The investigation also included several interviews with staff members who reported the AP offered to give the resident his pills. One staff member reported the AP came in on her day off to see the resident and to give him his medication. Other staff members reported the AP asked them for Adderall from their personal supply. The investigation indicated the resident received all prescribed medications and had not been affected by the incident. The AP had been suspended pending the investigation, and nursing staff received education on missing medication and drug diversion. The facility ended the AP's employment.

The investigation also included a timeline based on the surveillance footage. The AP entered the unit on which the resident resided. The AP went into nurse 3's office and grabbed the medication cart keys. The AP then opened several drawers on the medication cart. Nurse 1

walked back from her break, and the AP walked away from the cart. The AP gave the cart keys to nurse 1, then both staff went into the medication room. After leaving the medication room, the AP held a syringe in her hand, then dropped something. The AP then helped a staff member get something out of the top drawer of the medication cart. The AP got the keys back from nurse 1, then nurse 1 left the area. The AP opened the drawer containing the controlled substance lock box. The AP opened the locked box, removed a bubble pack sheet of medication and removed a pill. A staff member walked up to the AP, and the AP put the bubble pack away. The staff member left the area, and the AP removed another bubble pack, but keeping it in the drawer, removed another pill and placed it on the top of the medication cart. Nurse 1 then walked up to the AP and medication cart. The AP followed nurse 1 into the medication room with a medication cup in her hand. Then, the AP drew up medicine from a vile with a syringe and grabbed the medication cup. She left the room and dropped off both items at the nurse desk. The AP opened the top medication cart drawer, moved the med cup from the desk to the top of the medication cart, and grabbed the syringe. After that, the AP went to and from the medication cart for over an hour before finally exiting the unit.

Surveillance footage showed the AP had been the only person in the medication cart and its locked controlled substances box during the time period in question.

Text messages indicated three days prior, the AP asked nurse 1 to hold off on giving the resident his medication so she could bring him an ice cream. One day prior to the incident, the AP texted nurse 1 she wanted to bring the resident a birthday treat and requested she hold off on giving him his pills again.

During an interview, nurse 1 stated she dropped off the keys in nurse 3’s office when she went on break. When she returned, she could see the AP at her medication cart. The AP had her keys and said she had been looking for a syringe. The AP stayed in the area for a while. As soon as the AP left, nurse 1 went to start her evening medication pass. When she went to prepare the resident’s medication, she noticed one pill of Adderall missing. Nurse 1 knew it was correct earlier because she gave the morning dose. Nurse 1 told the administrator and director of nursing (DON) about the missing pill. Nurse 1 stated she had been suspicious of the AP. She and other staff members had experiences with the AP coming over to the unit and offer to give the resident his pills.

After the interview, nurse 1 provided additional information via text. Nurse 1 wrote the AP never brought the resident a shake. The AP would do that often, which is why nurse 1 became suspicious. The AP would come to the unit, say she wanted to visit the resident and ask if nurse 1 already brought his pills. If nurse 1 had already administered the pills, the AP would go back to her unit without visiting the resident.

During an interview, nurse 2 stated the facility kept the resident’s Adderall on the unit medication cart’s locked box for controlled substances. Nurse 2 received a report nurse 1 had been preparing to administer the resident’s Adderall when she found one pill missing. They

checked all over, including the locked box and surrounding area but were unable to find it. Nurse 1 reported her suspicions the AP might have taken it due to previous text messages asking nurse 1 to hold off on giving the resident his medications. During the investigation, the AP denied taking the Adderall pill. The investigation also included watching surveillance footage which showed the AP in the locked box for controlled substances a couple of times. Additionally, the AP had been on the unit, away from her own unit, for over an hour. The AP should not have been away from her unit for so long. The surveillance footage showed the AP with the keys, looking for something. After the investigation, nurse 2 began receiving reports from different staff about the AP and Adderall. An unlicensed personnel (ULP) informed her that earlier in the month, the AP told the ULP not to give the resident his p.m. dose of Adderall because the AP would be coming in to give it. Nurse 2 stated there would be no reason for this. Another nurse reported the AP previously wanted to come over to the unit to give the resident his medication. Additionally, another staff member reported the AP would ask the staff member for one of their personal supplies of Adderall.

During an interview, the administrator stated the medication count for the resident's Adderall had been correct prior to nurse 1 leaving for break, but after she returned and went to give the medication, the count had been off. Nurse 1 left the medication cart keys in nurse 3's office for her break. The AP arrived and remained on the resident's unit for about an hour and a half while assigned to another unit. During this time, the AP went into the medication cart and opened drawers. During the investigation, other staff reported the AP would come to the unit and offer to help pass medications.

During an interview, nurse 3 stated the nurse on duty normally did not leave for break until everything had been done, so staff from other units did not usually come onto the resident's unit. The nurse on duty normally reported off to her for their breaks, unless she had been in a meeting or off work. The day of the incident, nurse 1 took her break late and left the keys on nurse 3's desk. Nurse 3's office door had been shut but not locked when she went for a meeting. Nurse 3 remembered the AP being over on the resident's unit when she left for her meeting. After the investigation, a nurse told nurse 3 a couple days before the incident, the AP offered to give the resident his medication because it was his birthday, and she wanted to tell him happy birthday.

During an interview, the AP denied taking the resident's Adderall pill. The AP stated she went to the resident's unit to look for a specific type of morphine syringe. Later, she offered to give another resident a tuberculosis test and a pain pill. The AP stated that's why she went into the locked controlled substance box. The AP stated she did not work on the unit often, which was why she looked through and possibly pulled another blister pack. The AP stated there had been a period of time when she often brought ice cream treats to the resident because he enjoyed ice cream. She asked the nurse on the medication cart if he received his pills yet because the Adderall could suppress his appetite.

During an interview, the resident did not remember the incident.

During an interview, the guardian had not been made aware of the incident.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility completed an internal investigation and notified law enforcement. The AP is no longer employed at the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Koochiching County Attorney
International Falls City Attorney
International Falls Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H53188282M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the	

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2 000	Continued From page 1 #H53188282M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints,	21850		

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21850	Continued From page 2 except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		