Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53296065M
Compliance #: H53292773C

Date Concluded: April 8, 2026

Name, Address, and County of Licensee Investigated:

Warroad Care Center
1401 Lake Street NW
Warroad, MN 56763
Roseau County

Facility Type: Nursing Home

Evaluator's Name: Lisa Coil, RN, BSN
Paul Spencer, RN BSN
Special Investigators

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 narcotic medication from the resident's medication supply.

Investigative Findings and Conclusion: The Minnesota Department of Health determined financial exploitation was substantiated. The AP, a nurse, was responsible for the maltreatment. The AP had the morphine bottle in her possession and stated she had concerns with the bottle, she made no mention of this to her fellow nurse(s) until it was pointed out to her. A preponderance of evidence indicated she had possession and opportunity to tamper with and divert medication from the morphine bottle just before the nurses identified the same concerns during the narcotic count.

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

The resident resided in a nursing home. The resident's diagnoses included Alzheimer's. The resident's care plan included assistance with medication management and all cares. The resident's assessment indicated a decreased ability to make oneself understood or to understand others.

A concern arose one day when a nurse could not find a morphine bottle to do a scheduled narcotic count. When the nurse found the medication, she and another nurse found the morphine to be lighter in color and more liquid in the bottle than normal.

An internal investigation report indicated the facility identified a potential drug diversion had occurred due to a discrepancy identified during a routine narcotic count. The report indicated a nurse counted a bottle of blue-colored liquid morphine on A Wing [a unit within the facility] in the morning. However, when a different nurse went to complete the narcotic count in the middle of the afternoon it was missing. A third person, an unlicensed caregiver, reported seeing the AP in the medication cart in which the morphine was stored. The report indicated the AP was seen in the B Wing medication room about five to ten minutes later. When the AP was informed the bottle of morphine was missing, the AP said it was in her pocket because she was doing an audit.

The internal report indicated when the AP handed the bottle of morphine over it was found to be wet and the liquid was less blue than normal. The same document indicated three different employees found the bottle to be wet, the blue coloring was lighter than normal, and there were 40 milliliters (mL) instead of 30 mL in the bottle.

<u>Interviews</u>

During an interview, nurse #1 stated she and another nurse were performing the narcotic count, a bottle of morphine was missing. She also heard the AP had been in that medication cart located on A Wing at the beginning of the shift, so she tried to reach the AP but was initially unsuccessful. Nurse #1 stated she found the AP coming back from B wing and noticed the AP was bleeding from her finger. The AP told nurse #1 she had taken the morphine to complete an audit related to counting at shift change and gave the morphine to nurse #1.

During the same interview, nurse #1 stated she and nurse #2 removed the morphine bottle from the box and noticed the bottle of morphine looked like it had been opened and overfilled. Nurse #1 stated she informed the manager and the three of them looked at the morphine bottle together. Nurse #1 stated there was a stopper floating in the bottle and the three of them informed the AP of the concern. The manager and the AP emptied the liquid morphine into measuring cups and observed the liquid to be lighter shade of blue than normal and found

40 mL of liquid [which was 10 mL more than a normal bottle of morphine contains]. Nurse #1 stated the AP said they were not at the point to get law enforcement involved.

During the same interview, nurse #1 also stated the stopper in the bottle was not the one that came in the morphine box, which was still packaged in the box. Nurse #1 stated extra stoppers were stored in the B Wing medication room only. Nurse #1 stated there were two size stoppers and the one used in the morphine bottle was too small and apparently fell into the bottle. Nurse #1 also stated there was blood on the label of the morphine bottle.

During an interview, nurse #2 stated she entered medication room on B Wing earlier during the shift and saw the AP in there. Nurse #2 stated right away the AP asked her to check on a resident in another room, so she left the medication room. When nurse #2 returned the AP was still in the medication room, but the AP left the room shortly upon nurse #2's return. A short time later, nurse #1 asked her to look at the morphine bottle in the medication room on A Wing.

During the same interview, nurse #2 stated the outside of the bottle had spillage on it, the bottle had more liquid in it than it should, the seal had been taken off, and a stopper was floating inside the bottle. Nurse #2 stated she had done the narcotic count the previous night and, at that time, the morphine bottle had been sealed. Nurse #2 stated she and nurse #1 notified the AP and the manager of their identified concerns with the morphine bottle. The four staff members looked at the medication together and observed the liquid morphine had 40 mL in the bottle and was lighter blue than normal. Nurse #2 stated the normal amount contained in a bottle is 30 mL. Nurse #2 stated someone mentioned contacting law enforcement and the AP stated it was too early to do so.

During a phone interview the AP, with her lawyer present on the line, stated that day she was conducting an audit to make sure staff were counting narcotic medications. The AP stated she took what she thought was an unopened box of morphine to her office and, with the office door open, the medication did not sound right, so she opened the box and found the bottle had been opened. The AP stated she had already cut her finger prior to this. The AP stated she pulled back the lid and there was a plunger floating in the bottle, but the original syringe was still sealed in the package. The AP stated the morphine obviously had been tampered with since the plunger was in the bottle. The AP stated she closed the box, put it at the end of her desk, locked her office door, and headed to B Wing because she had to get it off her mind. The AP stated she was unable to report the incident to the administrator because they were out of the building. When asked who the next person(s) notified of the incident, the AP stated it was nurse #1 and nurse #2. When asked when nurse #1 and nurse #2 were notified, the AP stated we all kind of found it together when we were on A wing. When asked if the AP told nurse #1 and nurse #2 or if they notified the AP regarding the morphine bottle, the AP stated they came to her and said there was too much liquid in the bottle. When asked to clarify how nurse #1 and nurse #2 found too much liquid morphine in the bottle when it was locked in the AP's office, the

AP began to offer an explanation however at that time her lawyer interjected she was sharing too much background information and requested the interview be discontinued.

Written Statement

Later, the AP submitted a written statement in lieu of further interview. The AP's written statement indicated that while inspecting the morphine bottle, the AP discovered the foil was cut and put back into place to look like the bottle was closed. The statement indicated the AP grasped the loose piece of the foil and pulled it back and it came off. The AP then placed the foil in her scrub pocket before leaving her office.

The written statement indicated the AP went to B Wing medication room, where the facility's shift narcotic sign-off binder was typically located but it was not there. While the AP was in B wing medication room, she noticed a wrapper-mess on the counter, so she cleaned it up and discarded the trash along with the trash from her scrub pocket.

The written statement indicated the AP returned to her office and sat down. Shortly after that nurse #1 and nurse #2 came to the AP's office looking for the morphine. The AP gave nurse #1 the morphine. The written statement indicated the AP was notified by nurse #1, nurse #2, and the trained medication aide there was too much volume in the morphine bottle. The AP wrote none of those three staff members reported knowledge the morphine bottle had been opened, tampered, or compromised. The written statement indicated nurse #1, nurse #2, the manager, and the AP went to the medication room to look over the morphine bottle. After several attempts, the manager successfully removed the floating adapter and the liquid in the morphine bottle was measured at 40 mL and noted the morphine to be lighter blue in color. The statement indicated the AP's thumb was bleeding through a band-aid covering a cut she had received earlier, and it was observed by nurses that her blood got on the exterior of the morphine bottle.

The statement indicated the AP now spoke with the administrator and the administrator said not to call law enforcement but to continue investigating the incident.

The written statement also indicated concerns the AP had regarding policies and procedures related to narcotic medications. The concerns reviewed during the investigation included:

- The AP indicated in her written statement a specific registered nurse, who worked a minimum of four-night shift prior to this incident, left keys for two medication carts unsecured at the nurse's station and left both medication rooms unsecured. Review of staff schedules indicated the registered nurses worked one shift prior to the incident and the night of the incident. The schedule indicated the registered nurse was being trained by another nurse the night prior to the incident.
    - No other documentation of this event was identified beyond the AP's written statement.

- The AP indicated in her written statement the night shift registered nurse and day shift trained medication aide did not count the medication together as the policy indicated. The trained medication aide said she counted the medication alone and did not open the morphine box to check the morphine bottle.
    - The investigation identified documentation this was true the trained medication aide did count the medication alone.

- The AP indicated in her written statement two nurses on the same shift should not be counting medications together. Nurse #1 counted medication with the trained medication aide and later had nurse #2 look at the morphine bottle when she found a concern with the amount in the bottle and color of liquid in the bottle.
    - However, a review of the facility medication policy does not specifically state staff from the same shift cannot count medications together.

Policy Review

The facility's Medication Administration Policy indicated all controlled substance audits required two licensed staff. A review of the information provided by the AP indicated the AP conducted this audit of controlled substances without the assistance of another licensed staff member.

Conclusion

In her written statement the AP raises other possibilities of how the morphine was tampered although the concerns with the morphine bottle were not identified until the afternoon the AP took the bottle out herself. A preponderance of evidence indicated she was the person who tampered with the bottle as she admittedly removed the morphine from the narcotic box for an "audit". The AP acknowledged she identified concerns with the morphine bottle (including foil opened, and stopper inside). However, when nurse #1 sought her out in search for the morphine bottle, the AP did not share these concerns with nurse #1. While the AP indicated she sought out the administrator, she did not seek out a fellow nurse but rather claimed she inspected the morphine bottle alone.

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

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

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: No. The resident was not able to be interviewed.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility investigated the incident. The AP is no longer employed by 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 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 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
Roseau County Attorney
Warroad City Attorney
Warroad Police Department
Minnesota Board of Nursing

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD CARE CENTER	**1401 LAKE STREET NORTHWEST , WARROAD, Minnesota, 56763**

(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) COMPLETION DATE
20000	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: Initial comments: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H53296065M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	20000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota State Department of Health

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WARROAD CARE CENTER	**1401 LAKE STREET NORTHWEST , WARROAD, Minnesota, 56763**

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20000	Continued from page 1 #H53296065M, 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.	20000		
21850	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 14 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, 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 LICENSURE 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		