Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203818042M
Compliance #: HL203818702C

Date Concluded: April 3, 2026

Name, Address, and County of Licensee Investigated:
Brookdale Edina
3330 Edenborough Way
Edina, MN 55435
Hennepin County

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

Evaluator's Name: James Larson, RN
Special Investigator

Finding: Not Substantiated

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), a facility staff member, financially exploited the resident when three oxycodone tablets (a narcotic pain reliever) were discovered missing from the resident's supply.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was not substantiated. Although narcotic medication went missing, the resident did not miss a dose of scheduled narcotic pain medication, and the facility reimbursed the resident for the missing medications.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigation included review of the resident records, facility internal investigation documents, facility incident reports, personnel files, law enforcement report, and related facility policy and procedures. Also, the investigator toured the facility and observed staff administering narcotic medication.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure, kidney failure, Chronic Obstructive Pulmonary Disease (COPD). The resident's service plan included assistance with activities of daily living including housekeeping, laundry, safety checks and medication management. The resident's assessment indicated that the resident could communicate her needs.

A review of the resident's medical record indicated that the medication administration record was properly attested accurate by the AP and the off going staff person at the beginning of the AP's evening shift that day. The AP documented during the shift that she had administered two tablets of the narcotic pain medication (Oxycodone) to the resident. The AP failed to follow facility policy at the end of the shift when she left the facility and did not allow for the oncoming shift to verify the count of the available medication before she left the facility. The oncoming staff conducted a count and identified that a total of five pills were dispensed from the resident's supply during the AP's shift although only two pills were documented in the electronic health record and the narcotic logbook record.

When informed of the discrepancy, nursing staff questioned the AP who denied knowing anything about the three missing and unaccounted pills. The AP reported to nursing staff she did not release the keys to the locked narcotic storage area to any other person during the shift but admitted she did not follow protocol when leaving at the end of her assigned shift and failed to validate the narcotic supply with the oncoming staff.

Police were notified of the incident. The investigation was closed as there was no witness or video evidence of the incident.

The AP did not respond to requests for interview and did not respond to the subpoena request sent by the investigator.

During an interview, an administrator stated that the AP denied knowledge of the whereabouts of the missing medication and continually denied involvement. The missing medication was not recovered. The facility worked with the resident's pharmacy to identify the cost of the three missing pills and an equivalent onetime monetary credit was placed on the resident's account.

During an interview, the nurse stated the AP had been retrained on proper medication process and procedures prior to the incident. Upon notification of the incident, the nurse completed an internal medication audit and searched the facility, although the missing medication was not recovered. During the audit, the nurse was able to verify that the medication was prescribed to the resident on an as-needed basis to relieve pain and further verified that the resident had not missed any doses due to the incident.

During an interview with the resident, she had no concerns over the care she had received. She had no knowledge of the missing medication, nor could she identify ever missing a dose of a requested medication while living at the facility.

During an interview, a family member stated that they had knowledge of the incident as reported to them by the facility and had no further concerns over the care the resident has received at the facility.

In conclusion, the Minnesota Department of Health determined financial exploitation was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means: (a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No. The AP did not respond to multiple attempts to interview.

Action taken by facility:
The alleged perpetrator was placed on suspension immediately and her employment was terminated following the investigation. Facility staff were provided education on the procedure for shift change narcotic count.

Action taken by the Minnesota Department of Health:

No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20381	A. BUILDING: _____ B. WING _____	C 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDINA	3330 EDINBOROUGH WAY EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On January 13, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL203818702C/#HL203818042M. No correction orders are issued.	0 000		