Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240771020M
Compliance #: HL240774980C

Date Concluded: May 5, 2026

Name, Address, and County of Licensee Investigated:
SummerWood of Chanhassen
525 Lake Drive
Chanhassen, MN 55317
Carver County

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

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Inconclusive

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 AP financially exploited multiple residents (R1, R2, R3, and R4) by diverting their medications (lorazepam, Seroquel, and Trazadone) for her own use.

Investigative Findings and Conclusion: The Minnesota Department of Health determined financial exploitation by drug diversion was inconclusive. The missing medications were not scheduled II controlled medications tracked by the facility to identify potential diversion. Therefore, there was no documentation to show the medication to demonstrate diversion occurred. Based on the evidence available, it could not be determined if the AP was responsible for drug diversion as numerous staff members had access to the medications the medications when the suspected diversion occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members. The investigation included review of the resident record(s), pharmacy records, facility internal investigation, personnel files, staff schedules, law enforcement report, and related facility policy

and procedures. Also, the investigator observed residents and staff at the facility and medication storage.

The residents resided in an assisted living memory care unit and received medication management and administration services which included weekly medication audits.

During routine weekly medication audits in January the facility became aware of concerns with missing resident medications (lorazepam, Seroquel, and Trazadone).

Resident #1
Resident #1's medication administration record (MAR) included orders for lorazepam 1 milligram (mg) solutab scheduled four times daily and as needed (PRN).

A facility investigation indicated 2 tablets of the residents PRN lorazepam were unaccounted.

The resident's progress notes indicated weekly medication audits were completed and in compliance with no discrepancies or missing medication noted.

The residents MAR indicated the AP had not documented administering PRN Ativan to the resident during the time the diversion occurred. Although the AP administered medications to the resident other staff also had access and administered medications to the resident during the time the diversion occurred.

While drug diversion may have occurred, it could not be attributed to the AP specifically.

Resident #2
Resident #2's MAR included orders for lorazepam 0.5 mg twice daily PRN.

A facility investigation indicated a bubble pack card with approximately 18 lorazepam were missing. The facility investigation indicated video surveillance reviewed from the previous day showed the AP leaving the resident's room with a rectangular shape (consistent with a medication card) in her front hoodie pocket, then entered the office and put the card into her personal backpack. The investigation indicated when the AP left the office the object was no longer in the AP's pocket.

A review of the facility video showed the AP leave the resident's room with a rectangular object in her hoodie pouch pocket, the rectangular object appeared heavy pulling down on the fabric of the AP's pocket as she entered and exited the office. The unknown object was inconsistent with the weight expected from a medication bubble pack card. The AP was not observed to put a medication card into her backpack, and no backpack was observed on video as indicated by the facility investigation.

The resident's progress notes indicated weekly medication audits were completed and in compliance with no discrepancies or missing medication noted.

The resident's MAR indicated PRN lorazepam was not documented as given by any staff during the time diversion occurred. The MAR indicated numerous staff accessed and administered medications during the time of the diversion.

While drug diversion may have occurred, it could not be attributed to the AP specifically.

Resident #3
Resident #3's MAR included orders for PRN Seroquel 25 mg once daily for agitation.

A facility investigation indicated a full bottle of PRN Seroquel (unknown quantity) was missing.

The resident's progress notes indicated weekly medication audits were completed and in compliance with no discrepancies or missing medication noted.

The resident's MAR indicated PRN Seroquel was not documented as given by any staff during the time diversion occurred. The MAR indicated numerous staff accessed and administered medications during the time of the diversion.

While drug diversion may have occurred, it could not be attributed to the AP specifically.

Resident #4
Resident #4's MAR included orders for PRN Trazadone 0.5 mg daily.

A facility Investigation indicated a medication card of PRN Trazodone 25mg had 9 pills punched out but only one was documented as administered. The investigation indicated staff were educated on documenting the administration of medications per facility policy.

The resident's progress notes indicated weekly medication audits were completed and in compliance with no discrepancies or missing medication noted.

The MAR indicated the AP documented administering PRN Trazadone to the resident, 2 days later the medication was identified as missing. The MAR indicated numerous staff accessed and administered medications to the resident during the time of the diversion.

While drug diversion may have occurred, it could not be attributed to the AP specifically.

Although lorazepam is a schedule III-controlled medication, the facility policy indicated they provided tracking and accountability for only scheduled II controlled medications. As a result, there was no tracking or accountability records to review for resident #1, and resident #2's missing lorazepam.

Facility investigation documentation indicated when they became aware of concerns with missing medications, daily medication audits were initiated. The daily medication audits were requested but were not available for the investigator to review. The facility investigation documentation indicated the AP was the only staff who worked each of the 4 days when medication was identified as missing.

However, a review of the AP's scheduled shifts indicated the AP was scheduled to work with the residents who had missing medications only 2 of the 4 days. In addition, there was no way to know which shift the medications went missing prior to the daily audits being completed.

A law enforcement report indicated the facility reported missing resident medications. The report indicated facility leadership suspected the AP because the medications missing were antidepressant medications. The law enforcement report indicated the AP denied diverting any medications from residents and the case was closed pending new information.

During interviews and communication with facility leadership they indicated initially when a resident's PRN Trazadone was unaccounted for, they thought it was due to staff not documenting when the medication was administered. Leadership indicated when other medications went missing, they suspected diversion had likely occurred, but they did not have proof.

When interviewed the AP denied diverting any of the residents medications.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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, unable due to cognitive impairment or deceased at the time of the investigation.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility reported the concern to the Minnesota Adult Abuse Reporting Center (MAARC) and law enforcement, investigated the concern, and educated staff on documenting medication administration.

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
	24077	A. BUILDING: _____ B. WING _____	C 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF CHANHASSEN	525 LAKE DRIVE CHANHASSEN, MN 55317

(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 March 24, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL240771020M/#HL240774980C. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	