Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL245549522M
Compliance #: HL245543860C

Date Concluded: April 3, 2026

Name, Address, and County of Licensee Investigated:
Good Samaritan Society Heritage Grove
2122 River Road NW
East Grand Forks, MN 56721
Polk County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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 resident #1, resident #2, and resident #3 when the AP took the residents' narcotic medication for her own personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP admitted to law enforcement that she had taken narcotic medications from resident #1, resident #2, and resident #3 for her own personal use.

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 reports, personnel files, staff schedules, law enforcement report, and related facility

policy and procedures. Also, the investigator observed medication administration and narcotic storage at the facility.

Resident #1 resided in an assisted living facility. The resident's diagnoses included chronic obstructive pulmonary disease. The resident's service plan included assistance with medication administration. The resident's assessment indicated facility staff managed and administered the resident's medications.

Resident #2 resided in an assisted living facility. The resident's diagnoses included hypertension. The resident's service plan included assistance with medication administration. The resident's assessment indicated facility staff managed and administered the resident's medications.

Resident #3 resided in an assisted living facility. The resident's diagnoses included congestive heart failure. The resident's service plan included assistance with medication administration. The resident's assessment indicated facility staff managed and administered the resident's medications.

The police report indicated they were called to investigate prescription medications being tampered with and swapped with Tylenol. Law enforcement reviewed six medication cards. Resident #1's Percocet card had 22 pills in the card, 10 of which had been tampered with and replaced. It was noted to have been replaced with 9 acetaminophen and one metformin (a medication for diabetes). Resident #2 had four medication cards tampered with. Card #1 was hydrocodone and 9 of the 30 pills had been tampered with and replaced with acetaminophen. Card #2 was also hydrocodone and 2 of the 3 pills in the card had been tampered with and replaced with acetaminophen. Card #3 was another card of hydrocodone and 6 of the 15 pills had been tampered with and replaced with acetaminophen. Card #4 was another hydrocodone and 2 of the 30 pills had been tampered with and replaced with acetaminophen. Resident #3 had one card of oxycodone and all 17 pills had been tampered with. One of the look-alike pills was identified as atorvastatin, a cholesterol medication.

Facility administration identified that the AP was administering resident #1's PRN oxycodone at a significantly higher rate than other ULP, averaging 2 doses given per shift. Management reviewed surveillance footage that showed on one day, the AP documented she gave three doses of Oxycodone to resident #1 however she was only seen bringing a medication cup to the resident's room on one of the times she documented she gave the medication.

The AP was interviewed by law enforcement and she initially admitted to taking some narcotic pain medications, around ten pills. The AP stated the most pills she took in one shift was six pills. The AP later admitted to popping pills out, replacing them with Tylenol she brought from home, and taping them shut. The AP didn't know how many total pills she took. The AP stated she took the narcotic medications because of her ankles and she'd take a pill up to every three hours, sometimes as many as ten per day. The AP agreed to take a urine test, which was positive for oxycodone.

During an interview, a facility nurse stated she was responsible for the monthly medication exchange and she would also audit narcotics as part of that process. The nurse stated at the time, it was an accepted facility practice to tape narcotics back into the card but she noticed there was a lot more taping of medications than usual and when she started looking at the cards, the medications didn't look right. The nurse stated she and facility management used an app to identify what the pills were and it was identified as Tylenol. The nurse stated at that point, the looked for who could have swapped out medications and reviewed administration patterns and noticed that the AP had been giving narcotics more than other staff were. Camera footage was reviewed which showed the AP had documented she administered a narcotic medication but was never observed entering that resident's room. The nurse stated when the AP was interviewed, she admitted to taking the medications. The nurse stated the AP had only worked at the facility for a few months but had been a hardworking and compassionate employee who had a lot of experience as a caregiver and staff had not previously suspected she was taking narcotic medications.

At the time of the report, the AP had pending charges including three counts of felony theft of a controlled substance and one count of felony fifth-degree controlled substance possession, as well as a misdemeanor DWI charge.

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:
(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: Resident #1, Resident #2, Resident #3, yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Attempted

Action taken by facility:

The facility identified medications taped back into the package that did not match the prescribed medication. The facility investigated the incident, reported it to police and reported it to MAARC. The AP was terminated. The facility put new processes in place to prevent a reoccurring incident.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
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
Polk County Attorney
East Grand Forks City Attorney
East Grand Forks Police Department
Drug Enforcement Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24554	A. BUILDING: _____ B. WING _____	C 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-HERITAG	2122 RIVER ROAD NW EAST GRAND FORKS, MN 56721

(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 ******ATTENTION*** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL245549522M/#HL245543860C On March 16, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL245549522M/#HL245543860C tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure three of three residents reviewed (R1, R2, R3) were 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.	02360	Refer to the public maltreatment report sent separately. No plan of correction required for this tag.	