DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL289646882M
Compliance #: HL289646342C

Date Concluded: January 23, 2026

Name, Address, and County of Licensee Investigated:

Progressive Care LLC
1420 Prairie Avenue
Glencoe, MN 55336
McLeod County

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

Evaluator's Name: Jana Wegener, 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 diverted 17 as needed (PRN) oxycodone (a schedule II-controlled pain medication).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP repeatedly left assigned duties in a different unit to administer the resident's scheduled and PRN oxycodone and was the only staff to document giving the resident 17 doses of PRN oxycodone. The resident and staff denied the resident had unrelieved pain or need for the PRN. The resident record showed no utilization of the PRN prior to or following the incident.

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

substance logs, pharmacy records, facility internal investigation, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident's and staff at the facility and controlled drug medication storage.

The resident resided in an assisted living facility secured memory care unit with diagnoses including Parkinson's Disease, Alzheimer's dementia without behavioral disturbances, and low back pain.

The resident's assessment and plan of care indicated the resident had severe cognitive impairment and was at risk for abuse due to cognitive deficits. The assessment and plan of care indicated the resident received medication management and administration services. The plan of care directed all controlled medication would be counted by two staff at shift change, and all controlled medications would be double locked and signed out by two staff when given. Staff would notify the registered nurse (RN) of any concerns of diversion of medication.

The resident's medication administration record (MAR) included orders for oxycodone 5 milligram (mg) tablets, with instructions to give the medication scheduled twice daily and every six hours as needed (PRN).

During an onsite observation of the facility memory care unit storage, staff accessed the memory care medication storage closet using a master key, once inside the closet the keys to the narcotic lock box were laying on a shelf. As result, all staff working had unlimited access to the resident's oxycodone medication.

The resident's counting and tracking log used to ensure accountability of the resident's oxycodone indicated poor compliance of two staff completing a change of shift count on controlled medications and having a second staff witness the administration of the controlled substance. Licensing orders were issued to the facility.

Facility internal investigation documentation indicated several staff reported the AP had conduct concerning for drug diversion including; being the only staff to administer 17 PRN oxycodone to the resident, asking staff to alter the resident's oxycodone count documentation to be correct when a discrepancy occurred, asking staff to document the administration of PRN and scheduled oxycodone to the resident under another staff's log in, and repeatedly insisting on providing cares and medication administration services for the resident when another staff, not the AP, was assigned to the resident.

The resident's MAR and controlled drug counting and tracking log for the resident's oxycodone indicated the AP was the only staff to administer the PRN pain medication to the resident 17 times over seven weeks. The MAR showed the resident had not used the oxycodone prior to when the AP started administering it and had no utilization or need for the PRN following the AP's allegation of diversion and suspension.

The resident's progress notes failed to indicate the resident was having signs, symptoms, or reports of unrelieved pain to show an indication or need to administer her PRN oxycodone at the time the AP documented giving the PRN pain medication.

The resident's pain assessment following the incident indicated the resident denied having pain.

A review of the AP's scheduled assignments and time clock punches in comparison to the residents MAR indicated the AP had documented administering scheduled and PRN oxycodone to the resident a total of 28 times when the AP was assigned as a float or to other resident group/wing (not assigned to pass medications to the resident). At these times, another staff, not the AP, was assigned to provide cares and medication administration services to the resident. At times, the AP would arrive early to her shift, document administering oxycodone to the resident and at times document administering oxycodone just before leaving her shift. The AP's schedule indicated she was not assigned to administer medications to the resident.

Even though staff identified the AP's conduct was odd and concerning for diversion that continued for months there was no indication any of them reported their concerns to facility leadership.

During an interview, facility leadership stated the resident was the only one in the facility prescribed scheduled and PRN oxycodone pain medication. Leadership stated when staff reported their concerns, they investigated the incident, but the AP avoided answering questions and denied the allegation. Facility leadership stated the AP had administered PRN oxycodone to the resident prior to clocking into her assigned shift, left her assigned duties when working as a float on an assisted living group, or on the other memory care group to provide cares and medication administration to the resident. The conduct was unusual and inappropriate. Leadership stated staff should remain on their group assigned and do all cares and medications for those residents. Leadership stated a float did meals laundry and assisted as needed but did not generally provide any medication administration unless specifically asked to do so by the staff assigned. Leadership stated one staff reported they asked to go with when the AP administered PRN oxycodone to the resident, but the AP refused. Leadership stated the resident did not have any PRN oxycodone utilization prior to the incident, and no other staff had ever reported the resident had unrelieved pain or need for the PRN other than the AP. Leadership stated the AP was the only staff to ever give the resident PRN oxycodone 17 times. Leadership stated a pain assessment for the resident was conducted following the incident which failed to indicate the resident had unrelieved pain or need for the PRN. Leadership stated the resident had not utilized any PRN Oxycodone since the AP was suspended and her employment terminated (over 2 months following the incident).

Unlicensed personnel (ULP)#1 stated the resident never had signs symptoms or complaints of unrelieved pain, and indicated it was alarming the AP had given the resident oxycodone PRN and was the only one to ever give it. ULP#1 stated the AP would leave her assignment on another wing/group and go over to the memory care to do cares and administer medications to

the resident. ULP#1 stated no other staff did that. ULP#1 stated there were times at work when the AP appeared to be under the influence of something. ULP#1 stated the AP's conduct and PRN administration patterns went on for months before they were reported to leadership.

ULP#2 stated the AP had strange behavior towards the resident and would say "that's my girl, no one takes care of the resident like me." ULP#2 stated the AP would leave her assigned duties and residents on another unit and go to the memory care unit specifically to give the resident's medications and do her cares which was very unusual conduct. ULP#2 indicated it was not appropriate for the AP to leave her assigned group of residents to go to another wing/unit to pass medication for a specific resident and indicated no other staff ever did that. ULP#2 stated the resident never complained of unrelieved pain or needed PRN Oxycodone.

ULP#3 stated when staff work as a float, they do not administer medications unless specifically asked to do so by the staff assigned and indicated that was not a common practice. ULP#3 stated the resident never had unrelieved pain, complaints of pain, or need for a PRN. ULP#3 stated when the AP worked, she insisted upon caring for the resident when working as a float or on another wing. ULP#3 stated she had observed the AP appear to be under the influence of something by acting weird, more hyper than usual, and was sweating and shaking. ULP#3 stated during one change of shift count with the AP there was a discrepancy with a missing pill and the AP wanted ULP#3 to change the number and lie about how many pills were there. ULP#3 stated the AP could not explain where the missing oxycodone went, and stated she reported it to leadership.

ULP#4 stated the AP had odd behavior towards the resident, would leave her assigned duties and residents on the assisted living side to go to memory care to insist on providing cares and administer medications to the resident. ULP#4 stated it was not normal for staff to leave their assigned duties to go to another group and provide cares or pass medication if not assigned and without being asked to do so.

ULP#5 stated one day the AP came in early for her shift and gave the resident a PRN pain medication when ULP#5 was assigned to the resident. ULP#5 stated the AP said, "I usually give the resident a PRN at this time." ULP#5 stated she told the AP rounds were just done, and the resident was sound asleep with no signs or symptoms of pain and did not need a PRN, but the AP ignored ULP#5 and documented giving the PRN to the resident anyway. ULP#5 stated the AP had other strange conduct like leaving her assigned group to give scheduled and PRN oxycodone to the resident and refused to have a witness or assistance with cares and transfers even though the resident required two staff assist with transfers. ULP#5 stated it did not matter what assigned staff said or who was assigned to the resident the AP would insist and take over the resident's cares if she was not assigned.

ULP#6 refused to be interviewed. During the facility investigation ULP#6 reported the AP wanted ULP#6 to document administration of the resident's oxycodone under her login instead of under the AP's log in, but ULP#6 refused. ULP#6 reported similar odd conduct from the AP as

other staff including giving PRNs to the resident when she had no signs symptoms or reports of pain and doing the resident's medication when she was not assigned to do so.

ULP#7 stated the AP was the only staff to give the resident's PRN oxycodone which was odd because the resident did not have pain that was not relived with nonpharmacological interventions like repositioning, removing her socks, or providing a warm towel for comfort, and indicated the resident did not need a PRN narcotic for pain.

When interviewed the AP denied diverting oxycodone from the resident. The AP admitted leaving her assigned duties when not scheduled to work with the resident to provide care and administer the resident's medications including her scheduled and PRN oxycodone pain medication, and indicated it was because staff did not take care of the resident the way she did. The AP stated she was retaliated against by this facility and the previous facility she worked for because she had voiced concerns when things were not done correctly resulting in them making false allegations against her. The AP denied having a history of substantiated oxycodone diversion at a previous facility when asked and stated she was investigated for medication errors. The AP denied conduct concerning for diversion including logging into the computer system and administering PRN prior to her scheduled shift. The AP denied giving 17 PRNs to the resident, and stated she was not afraid to give the PRN, but other staff were. The AP denied giving a PRN prior to her scheduled shift and stated she had worked multiple shifts that day and was told to punch out but continued to assist staff, which was when she gave the resident's PRN, however the AP was not scheduled any other shifts that day. The AP denied asking staff to alter count or administration documentation.

When interviewed the resident denied having pain.

When interviewed the resident's family stated the resident's pain was well controlled with the scheduled pain medication twice daily, and indicated the resident did not have any unrelieved pain or need a PRN Oxycodone.

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

Action taken by facility:
The facility reported concerns of diversion to the Minnesota Adult Abuse Reporting Center (MAARC), suspended the AP, and investigated the incident. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in 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

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
Mcloed County Attorney
Glencoe City Attorney
Glencoe Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	28964		C 12/22/2025

NAME OF PROVIDER OR SUPPLIER

PROGRESSIVE CARE LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

1420 PRAIRIE AVENUE
GLENCOE, MN 55336

(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: HL289646882M/HL289646342C On December 22, 2025, 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 73 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL289646882M/HL289646342C, tag identification 1700, 1880, and 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.	
01700 SS=F	144G.71 Subd. 2 Provision of medication management services	01700		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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01700	Continued From page 1 (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure interventions to prevent diversion of medications for one of one resident's (R1) with records reviewed. Staff failed to consistently complete change of shift controlled substance counts, witnessed administration of controlled medications, report count discrepancies to nursing. This deficient practice had the potential to affect all residents and staff.	01700		

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01700	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the facility on December 1, 2020, with diagnoses including Parkinson's Disease, Alzheimer's dementia without behavioral disturbances, and low back pain. R1's assessment and plan of care dated December 24, 2025, indicated R1 had severe cognitive impairment and was at risk for abuse due to cognition deficit and poor safety awareness. R1 required medication management and administration services. All controlled medications required counting by two staff at shift change. All controlled medications would be double locked and signed out by two staff when given. The plan of care directed staff would notify the registered nurse (RN) of any concerns of diversion of medication, and indicated an on call nurse was available 24 hours per day. R1's medication administration record (MAR) for August to December 2025, included orders for oxycodone 5 milligram (mg) tablets, with instructions to give the medication scheduled twice daily at 6:06 a.m. and 6:06 p.m. and every 6 hours as needed (PRN). R1's August 2025, counting and tracking log for oxycodone 5 mg, reviewed for change of shift	01700		

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01700	Continued From page 3 counts to be completed on every shift (days, evenings, and nights) with two staff. The log indicated two staff completed a change of shift count only 3 of 31 days in August 2025. The remainder of the days either no change of shift count was completed, or a change of shift count was done by one staff with no witness to verify the count was accurate and correct. R1's August 2025, counting and tracking log for scheduled administration at 6:06 a.m. and 6:06 p.m. reviewed for witnessed administration indicated only 3 of the 62 scheduled oxycodone administrations were witnessed by another staff member. The August 2025 counting and tracking log indicated discrepancies in the count occurred with two unaccounted for tablets, and indicated an RN was notified there, but there was no indication follow up to determine what happened to the two missing oxycodone 5 mg tablets. The first week of August 2025 tracking counting log for administration and witness was provided for examples, and discrepancies noted as follows: - On August 28, 2025, at 5:06 a.m. ULP staff documented administration, no witness (count 78) discrepancy was noted with 1 tablet unaccounted for. There was no indication the discrepancy was reported to nursing or what action was taken. - On August 29, 2025, at 6:34 a.m., ULP staff documented completing a change of shift count; no witness (count 76) and a discrepancy was noted with 1 tablet unaccounted for. There was no indication the discrepancy was reported to nursing. - On August 29, 2025, 6:52 p.m., the log indicated RN-N documented medication was count fixed, no witness, the count remained 75, there was no indication what happened to the 2 unaccounted for tablets in August 2025.	01700		

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01700	Continued From page 4 R1's August 2025, MAR and controlled drug counting and tracking log for R1's oxycodone 5 mg controlled drug pain medication indicated unlicensed personnel (ULP)-A was the only staff to administer the PRN pain medication to R1, five times in August 2025, with no witness. R1's PRN counting log and MAR indicated the following: - On August 23, 2025, at 12:51 a.m. ULP-A documented giving PRN oxycodone 5 mg pain medication for the first time for low back pain and foot pain, no witness. - On August 24, 2025, at 12:24 a.m. ULP-A documented giving PRN oxycodone 5 mg tablet for foot pain, no witness. - On August 25, 2025, at 12:38 a.m. ULP-A documented giving PRN oxycodone 5 mg tablet for foot pain, no witness. - On August 26, 2025, at 1:17 a.m. ULP-A documented giving PRN oxycodone 5 mg tablet for foot pain, no witness. - On August 27, 2025, at 1:11 a.m. ULP-A documented giving PRN oxycodone 5 mg tablet for foot pain, no witness. R1's progress notes dated August 2025, failed to indicate R1 was having signs, symptoms, or reports of pain or indication of need for staff to administer her PRN oxycodone on the days ULP-A documented giving the pain medication. R1's September 2025, counting and tracking log for oxycodone 5 mg, reviewed for change of shift counts to be completed on every shift (days, evenings, and nights) with two staff. The log indicated two staff completed a change of shift count on each shift only 1 of 30 days in September. The remainder of the days either no change of shift count was completed, or staff completed a change of shift count with no witness	01700		

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01700	Continued From page 5 to verify and ensure accuracy and accountability. R1 September 2025, counting and tracking log for scheduled administration at 6:06 a.m. and 6:06 p.m., reviewed for witnessed administration indicated only 1 of 60 scheduled administration times in September 2025, were witnessed by another staff. Although discrepancies were noted in September log counts indicating possible error in administration, and 1 unaccounted-for tablet there was no indication nursing was notified, or what action was taken to ensure accountability of R1's controlled drug oxycodone pain medication. The first week of September 2025, tracking counting log for administration and witness was provided for examples, and discrepancies noted as follows: - On September 6, 2025, at 7:36 p.m., ULP staff documented administration of R1 scheduled medication, no witness (count 59) - On September 7, 2025, at 6:09 a.m., ULP staff documented administration of R1 scheduled medication, no witness (count remained 59). A log note indicated the RN was notified of the discrepancy, however there was no indication what action was taken or if an administration omission error occurred. - On September 13, 2025, at 5:55 a.m., ULP staff documented administering 1 scheduled oxycodone, no witness. The log indicated a discrepancy was noted with 1 tablet was unaccounted for, however there was no indication the discrepancy was reported by staff or what action was taken to ensure accountability of R1's controlled pain medication. R1's September 2025, MAR and controlled drug counting and tracking log for R1's oxycodone 5 mg controlled drug pain medication indicated ULP-A was the only staff to administer the PRN	01700		

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01700	Continued From page 6 pain medication to R1, six times in September 2025, with no witness. Although the log indicated discrepancies occurred with 3 PRN oxycodone 5 mg tablets unaccounted for in September 2025, there was no indication any action was taken to ensure accountability of R1's oxycodone pain medication. R1's PRN counting log and MAR indicated the following: - On September 6, 2025, at 12:48 a.m. ULP-A documented administering 1 PRN oxycodone 5 mg tablet for toe foot pain, no witness. - On September 6, 2025, at 11:03 p.m. ULP-A documented administering 1 PRN oxycodone 5 mg tablet for pain, no witness. - On September 6, 2025, at 11:09 p.m. (6 minutes later) a change of shift count was completed with 2 staff ULP-A and another staff identified a discrepancy of 1 PRN tablet unaccounted for. The log indicated the RN was notified of the discrepancy, however there was no indication what action was taken to identify where the missing PRN tablet went. The scheduled administration log for this day had no errors to explain why the discrepancy occurred. - On September 8, 2025, at 12:35 a.m. ULP-A documented giving 1 PRN oxycodone 5 mg tablet for low back pain, no witness. - On September 20, 2025, at 12:07 p.m. ULP-A documented giving 1 PRN oxycodone 5 mg tablet for foot pain, no witness. - On September 21, 2025, at 11:22 p.m. ULP-A documented giving 1 PRN oxycodone 5 mg tablet for foot pain, no witness. - On September 27, 2025, at 10:10 p.m., ULP staff completed a change of shift count with no witness, a discrepancy was noted with 1 PRN oxycodone 5 mg tablet unaccounted for. The log failed to indicate the discrepancy was reported to nursing, and there was no indication any action was taken to identify where the missing PRN	01700		

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(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
01700	Continued From page 7 tablet went. The scheduled administration log for this day had no errors to explain why the discrepancy occurred. - On September 28, 2025, at 12:28 a.m. ULP-A documented giving 1 PRN oxycodone 5 mg tablet for foot pain, no witness. - On September 30, 2025, at 3:02 p.m., two staff completed change of shift count, a discrepancy was noted with 1 PRN oxycodone 5 mg tablet was unaccounted for. The log failed to indicate the discrepancy was reported to nursing, and there was no indication any action was taken to identify where the missing PRN tablet went. The scheduled administration log for this day had no errors to explain why the discrepancy occurred. R1's progress notes failed to indicate R1 was having signs, symptoms, or reports of pain or indication of need for staff to administer her PRN oxycodone on the days ULP-A documented giving the pain medication. R1's October 2025, counting and tracking log for oxycodone 5 mg, reviewed for change of shift counts to be completed on every shift (days, evenings, and nights) with two staff. The log indicated two staff completed a change of shift count on each shift only 4 of 31 days in October 2025. The remainder of the days either no change of shift count was completed, or staff completed a change of shift count with no witness to verify and ensure accuracy and accountability. R1 October 2025, counting and tracking log for scheduled administration at 6:06 a.m. and 6:06 p.m. reviewed for witnessed administration indicated only 5 of 62 scheduled administration times in October 2025, were witnessed by another staff.	01700		

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	28964		C 12/22/2025

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01700	Continued From page 8 R1's October 2025, MAR and controlled drug counting and tracking log for R1's oxycodone 5 mg controlled drug pain medication indicated ULP-A was the only staff to administer the PRN pain medication to R1, six times prior to October 13, 2025, with no witness. R1's PRN counting log and MAR indicated the following: - On October 2, 2025, at 12:06 a.m. ULP-A documented giving 1 tablet oxycodone 5 mg PRN for foot pain, no witness. - On October 4, 2025, at 1:35 a.m. ULP-A documented giving 1 tablet oxycodone 5 mg PRN for back pain, no witness - On October 6, 2025, at 1:10 a.m. ULP-A documented giving 1 tablet oxycodone 5 mg PRN for back pain, no witness. - On October 10, 2025, at 12:59 a.m. ULP-A documented giving 1 tablet oxycodone 5 mg PRN for back pain, no witness. - On October 13, 2025, at 1:11 a.m. ULP-A documented giving 1 tablet oxycodone 5 mg PRN for foot pain, no witness. R1's progress notes from August 2025, to October 13, 2025, failed to indicated R1 had signs/symptoms, reports of pain, or indication to administer the PRN oxycodone 5 mg tablets at the times ULP-A documented giving the medication to R1. R1 pain assessment dated October 16, 2025, following the incident indicated R1 had no reports of pain indicating a need for PRN oxycodone. The licensee lacked consistent change of shift counts by two staff and witness with administration of scheduled and PRN controlled medication which showed a failure to ensure processes were in place and followed to ensure accountability and identify/prevent potential	01700		

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01700	Continued From page 9 diversion of R1's controlled oxycodone pain medication. A review of R1's oxycodone 5 mg scheduled and PRN counting and tracking logs for November 2025, and December 2025, following the allegation of diversion and facility investigation showed problems with staff not consistently having a witness when administering R1's controlled pain medication and consistently not completing change of shift counts with two staff to ensure accountability and identify and prevent diversion were pervasive and was ongoing at the time the investigator was onsite. The undated licensee internal investigation documentation of R1's reported oxycodone 5 mg diversion indicated several staff had reported ULP-A had conduct concerning for drug diversion including being the only staff to administer 17 PRN oxycodone to R1, asking coworkers to alter the counts to be correct, asking to document administration of PRN and scheduled oxycodone to R1 under another staffs log in, and ULP-A had repeatedly provided cares and medication administration services to R1 when another staff not ULP-A was not assigned to R1. The licensee investigation failed to indicate they had identified 6 unaccounted for oxycodone 5 mg tablets in August 2025, and September 2025, or concerns with staff not consistently completing change of shift counts with two staff or had a witness when administering R1's controlled drug oxycodone pain medication. On December 22, 2025, at 2:30 p.m., ULP-D stated administration of R1's oxycodone did not need to be witnesses by another staff. ULP-D stated she thought the computer system alerted the nurse if the counts were off and indicated the	01700		

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01700	Continued From page 10 counts were off for a long time. ULP-D stated R1 never had complaints of or unrelieved pain, and indicated it was alarming ULP-A had giving R1 oxycodone PRN and was the only one to ever give it. ULP-D stated ULP-A's conduct and PRN administration patterns went on for months before they were reported. On December 23, 2025, at 12:25 p.m., director of nursing (DON)-B stated staff would email text of call the nurse on call if a discrepancy occurred and the nurse would investigate to determine what happened and correct the count. DON-B indicated the discrepancies were not true discrepancies with unaccounted for medications but were caused when staff had taken from the PRN card in error causing a discrepancy in the counts. DON-B stated a witness was required with each scheduled and PRN controlled drug administration not just change of shift counts. Documentation of staff reporting discrepancies and actions taken including investigation and finding was requested, none was provided. On December 30, 2025, at 5:00 p.m. during email communication to DON-B and executive director (ED)-C investigation documentation of any count discrepancies known or reported from August - October 2025 and the findings was requested, none was provided. On January 5, 2025, at 1:43 p.m., ULP-G stated during a phone interview there were times when staff did not have a witness when counting or giving R1's oxycodone and indicated they would call DON-B for approval and indicate that in the notes. ULP-G indicated they also had a camera in the medication closet to witness. On January 5, 2025, at 1:49 p.m., DON-B	01700		

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01700	Continued From page 11 indicated in email communication she had noticed some administration witnesses were missing on R1's narcotic counting log, but had not noticed staff were not consistently completing change of shift counts with two staff. Licensee policy and procedure titled "Delivery and Control of Controlled Substances Schedule II-IV Drugs" effective November 2012, indicated the licensee would take all reasonable precautions to eliminate the theft, diversion or misuse of controlled substances and would comply with requirements regarding the safe storage and disposal of these drugs. The licensee treats schedule III and IV controlled substances as strictly as schedule II. Staff are required to enter narcotic counts during time of administration and when completing narcotic counting at change of shifts within the EMAR. During the narcotic count staff should inspect both sides of the blister packs carefully for evidence of tampering, such as tape over foil, cuts or breaks in the foil, and inspect the medication for consistency in appearance. If any tampering is suspected, it should be reported to the RN immediately. Only trained staff will have a key to the narcotic storage to give medications. Staff will maintain control of their keys and their whereabouts during their shift. The policy indicated best practice was for narcotics to be counted at a change of shift. Two trained medication staff will count the controlled medications together and will document and report any discrepancies immediately to the RN. If controlled drugs are missing, the RN or Clinical Nurse Supervisor, working with the Executive Director, would investigate and try to determine when the drugs went missing and who may have been involved. Depending on the circumstances and the result of the investigation, the RN/Clinical Nurse Supervisor and the Executive Director will	01700		

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01700	Continued From page 12 decide whether it is appropriate to contact the police and/or MAARC. The RN/Clinical Nurse Supervisor and the Executive Director will work together to determine appropriate preventative actions to prevent future incidents, including termination of any employees determined to be responsible. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all controlled medications were securely locked in substantially constructed compartments and permitted only authorized personnel had access for one of one resident's (R1) with records reviewed for financial exploitation by drug diversion. This deficient practice had the potential to affect all residents and staff handling controlled medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when	01880		

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01880	Continued From page 13 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the facility on December 1, 2020, with diagnoses including Parkinson's Disease, Alzheimer's dementia without behavioral disturbances, and low back pain. R1's assessment and plan of care dated December 24, 2025, indicated R1 had severe cognitive impairment and was at risk for abuse due to cognition deficit and poor safety awareness. The assessment and plan of care indicated R1 required medication management and administration services. The assessment and plan of care indicated all controlled medications would be double locked. R1's medication administration record (MAR) for August to December 2025, included orders for oxycodone 5 milligram (mg) tablets, with instructions to give the medication scheduled twice daily at 6:06 a.m. and 6:06 p.m. and every six hours as needed (PRN). On December 22, 2025, at 3:40 p.m., during a tour of the licensee memory care storage with director of nursing (DON)-B, a locked closet door was observed. DON-B unlocked the door to the medication closet with a master key and inside the room a small bookshelf was observed with keys to the narcotic lock box attached to the wall in the closet with a single lock. DON-B stated all staff working in the facility no matter if they are a float or assigned on the assisted living side had access to open the memory care medication storage closet door with their master key and	01880		

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01880	Continued From page 14 then could access the narcotic lock box with the keys to the narcotic lock box stored inside the closet. DON-B stated all staff working had a master key that would open all the doors and resident rooms in the facility. As a result, anyone working in the building had unlimited access to the controlled medications stored in the memory care medication closet and narcotic box. On December 22, 2025, at 2:30 p.m., unlicensed personnel (ULP)-D stated all staff had a master key that opened all the doors in the facility including the medication closet in the memory care unit where R1 resided, and the keys to the narcotic lock box were on a shelf in the closet. On December 22, 2025, at 2:43 p.m., ULP-E stated all staff had access to the memory care unit medication closet and narcotic storage using a master key and then the key to the locked narcotic storage was inside the closet. On December 23, 2025, at 12:25 p.m., the surveyor discussed concerns with all staff having unlimited access to the memory care medication storage closet and the keys to the narcotic lock box presenting a concern for potential diversion was reviewed with DON-B. DON-B stated understanding of the concerns and stated they would get it fixed right away and email actions taken to ensure the controlled medications were secured. On December 24, 2025, at 9:24 a.m., email communication from DON-B indicated they had purchased a double locked narcotic storage box for the memory care closet and removed the keys from the closet and were now only on the keys for staff assigned to administer medications to the residents.	01880		

Minnesota Department of Health

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01880	Continued From page 15 On January 5, 2026, at 2:21 p.m., ULP-H stated she had worked on the memory care unit the previous day and stated the keys to the narcotic lock box remained inside the medication cupboard for all staff to have access using the master key. ULP-H denied receiving any education on changes to the medication storage on the memory care unit and indicated narcotics were stored in the same way as they always had been the last time she worked. On January 6, 2026, at 12:39 p.m., DON-B stated during a phone conversation they had implemented double locked narcotic storage in the memory care medication storage closet and the keys to the narcotic storage were on the key chain assigned to staff who were working and passing medications in memory care and not stored in the closet. Licensee policy and procedure titled "Delivery and Control of Controlled Substances Schedule II-IV Drugs" effective November 2012, indicated only trained staff will have a key to the narcotic storage to give medications. Staff will maintain control of their keys and their whereabouts during their shift. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	01880		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment	02360		

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02360	Continued From page 16 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to ensure one of one residents (R1) reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility.	02360		